ASSESSMENT OF USAID/BRAZIL POPULATION ASSISTANCE STRATEGY

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ABBREVIATIONS

ABEPF	Associacao Brasileira de Entidades de Planejamento Familiar
AIDS	acquired immunodeficiency syndrome
AIDSCAP	AIDS Control and Prevention Program
BEMFAM	Sociedade Civil Bem-Estar Familiar No Brasil (Brazil)
CA	cooperating agency
CHW	community health worker
CPO	contraceptive procurement organization
CPR	contraceptive prevalence rate
CYP	couple year of protection
DIRES/DERES	Directoria Regional de Salúde/Departamento Regional de Saúde (Regional Health Directorate/Regional Health Department)
DHS	demographic and health survey
FHI	Family Health International
FY	fiscal year
GOB	Government of Brazil
HIV	human immunodeficiency virus
HMO	health maintenance organization
IBGE	Instituto Brasileiro de Geografia e Estatistica
ICPD	Cairo International Conference on Population and Development
IEC	information, education, and communication
INMETRO	Instituto Nacional de Metrologia, Normalização e Qualidade Institucional (National Institute of Measurement, Standards and Institutional Quality)
INOPAL	Operations Research in Family Planning and Maternal-Child Health for Latin America and the Caribbean (project)
IPC/C	interpersonal communication/counseling
IPPF	International Planned Parenthood Federation
IPPF/WHR	International Planned Parenthood Federation/Western Hemisphere Region
ISDS	Institute for Health and Social Development
IUD	intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
MIS	management information system
MOH	Ministry of Health
NGO	non-governmental organization
OCs	oral contraceptives
PAHO	Pan American Health Organization
PAISM	Programa de Assistencia Integral de Salúde da Mulher (Integral Woman's Health Care Program)
PCS	Population Communication Services (project)
PESMIC	Pesquisas de Saude Materno-Infantil do Ceará (health study)
PHN	Center for Population, Health, and Nutrition
PP/PA	postpartum/postabortion
PROFIT	The Promoting Financial Investments and Transfers Project
SAMEAC	Federal University Maternity School
SDP	service delivery point

SESAB	Secretaria da Saúde do Estado da Bahia (Bahia State Secretariat of Health)
SIA/SUS	Sistema de Informacoes Ambulatoriais/Sistema Unico de Saude
SISMAC	Sistema de Monitoreo e Avaliação Continuos (Continuous Monitoring and Evaluation System)
SOMARC	Social Marketing for Change (project)
SUS	Sistema Unico de Saúde (Single Health System)
TA	technical assistance
TBA	traditional birth attendant
TOT	training of trainers
UNCED	United Nations Conference on Environment and Development
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Background

Demographic and Socioeconomic Overview. Brazil is an advanced developing country in terms of its demographic and socioeconomic indicators, though it is also characterized by marked differentials in these indicators among regions and social classes. Population growth has slowed substantially: total fertility is now estimated to be about 2.8 and contraceptive prevalence close to 70 percent. Improvements in health, including reproductive health, have generally lagged behind advances in other social sectors. Maternal mortality, for example, is estimated at 200 per 100,000 live births.

Northeastern Brazil continues to lag behind the rest of the country in terms of social indicators. The total fertility rate has declined, but was still higher (at 3.7 in urban areas and 5.2 in rural areas in 1991) than the rest of Brazil. The Northeast's contraceptive prevalence rate was 59 percent in 1991, which was still below the national level figure of 65 percent in 1986.

While awareness of the existence of contraceptive methods is almost universal, actual use remains concentrated in two methods: female sterilization and the birth control pill. Poor use of pills has contributed to continued widespread abortion. Sterilizations are generally done in conjunction with a cesarean birth, providing a "cover" for the procedure, which has ambiguous legal status.

Organization of the Health Sector. Over the past decade the Brazilian government has implemented a massive institutional, organizational, and financial reform of the public health care sector, shifting responsibility for health care provision from the central government to municipalities.

Under the new, decentralized Single Health System (Sistema Unico de Saúde - SUS), each state is expected to constitute a single "system" and be responsible for its own municipal and state services. SUS faces some profound difficulties. The 1988 Constitution, with its open-ended commitment to free public health care for all, combined with on-going budgetary crises, has made it very difficult for states and municipalities to meet their new health care responsibilities.

Evolution of Family Planning. Family planning service delivery in Brazil has evolved differently from countries with organized national family planning programs. A disjointed mix of access channels has led to high prevalence put poor service quality and a narrow method mix in which the pill and sterilization predominate. Most Brazilian pill users acquire them at pharmacies. Sterilizations are performed in public as well as private facilities.

NGO involvement in direct delivery of family planning services has been limited, though NGOs have played an important role in training and IEC, along with working through contracts with corporations and municipalities to provide contraceptives, training, and other services. Under SUS, states and municipalities are responsible for implementation of the public sector women's health program Integral Women's Health Care Program (PAISM), which includes family planning.

USAID/Brazil Assistance for Family Planning. In the 1960s and 1970s, Brazil was a major recipient of U.S. bilateral aid, including population assistance. Since 1983, direct assistance to the government of Brazil has been prohibited because of outstanding debt and nuclear non-proliferation issues. USAID has, however, continued to provide population assistance to the PVO sector. From 1988 to 1994, USAID provided nearly US$50 million in population assistance to Brazil.

Since the beginning of USAID population assistance to Brazil and until adoption of the current strategy, USAID support was provided to a large number of institutions to carry out a wide range of activities in numerous key functional areas. Recipient institutions were scattered throughout the country. By providing this wide base of support, USAID was successful in helping to legitimize family planning in Brazil, mobilizing private support in the absence of public-sector involvement, creating a large pool of trained providers (particularly in the South and Southeast) many of whom now occupy senior positions in the public health sector and medical schools, and demonstrating effective approaches to service delivery. In order to phase-out population assistance to Brazil, the 1992 phase-out strategy called for narrowing the scope of activities supported by USAID to a limited number of key issues and for focusing on Brazil's poorest region, the Northeast.

The phase-out strategy has thus focused geographically on the Northeast region and programmatically on two important issues: improving family planning quality and promoting the sustainability of service delivery systems once USAID withdraws its support. By and large the objectives of the current USAID strategy are being accomplished. However, some retuning of the strategy is needed in recognition of the fact that the public sector, which in previous years has shown little interest in family planning (FP) and reproductive health (RH), appears to be moving more decisively in the direction of full-scale service provision.

The decision to "phase-out" rather than "pull-out" was and continues to be based on Brazil's geopolitical and socioeconomic importance to the US. As the largest country in Latin America, covering almost half the continent and with a population of 150 million, Brazil is an important diplomatic partner in such regional fora as the Rio Pact and as a guarantor in the Peru/Ecuador border dispute. With an economy on the order of US$530 billion, Brazil is relatively more advanced economically than other countries. Yet it still has major pockets of poverty, particularly in the Northeast where more than 45 million Brazilians live. Since long-term investments in population contribute to slowing of population growth and poverty reduction and because quality of care (QOC) in Brazil is so poor, phase-out assistance to sustain long-term investments over the long run should be provided. Brazil is also a major US trading partner (US$17 billion in 1994); it is thus in the US interest to assist Brazil in dealing with social problems that undermine its market potential.

Current Brazil Population Assistance Strategy and Implementation Plan. USAID's population assistance to Brazil is being phased out over the period 1993-2000. The objectives of the assistance strategy for this period are to:

- Improve the quality of family planning programs in Brazil by expanding the limited range of methods available, improving the use of methods, and increasing the information available about reproductive health.

- Ensure that there are viable service delivery systems in target areas when USAID assistance ends by working with states and the private sector to promote sustainability.

- Document the impact of USAID population assistance to Brazil through data collection and analysis at key points in program implementation.

Population assistance resources are being targeted on two states in Northeastern Brazil, Ceará and Bahia, where the combined population of the two states is over 20 million. A limited number of activities is also being carried out nationally to increase private sector involvement and to address such issues as regulatory reform and assurance of an adequate supply of contraceptive methods.

The strategy is being implemented through USAID's network of Cooperating Agencies (CAs) and their Brazilian counterparts, with a more limited focus on provision of specialized technical assistance in areas of policy, training, (IEC), social marketing, commercial sector involvement in family planning and commodities procurement, logistics management, research and evaluation. The implementation plan anticipates that most of the activities related to service delivery will conclude by 1997, leaving the final years for data collection and impact evaluation.

Purpose of the Assessment. The objectives of the USAID Brazil population assistance strategy are to improve program quality and promote sustainability of family planning services. The purpose of this assessment is to examine progress toward these objectives and to consider whether the objectives can be achieved within the planned phase-out period.

PROGRAM EVALUATION PLAN

Evaluation Framework and Indicators. The population strategy and implementation plan for Brazil call for development of an evaluation plan to permit assessment of the program's achievement of its objectives. With the assistance of the EVALUATION Project, an evaluation framework was developed that combines the elements of the USAID PRISM strategic objective methodology with an approach developed by EVALUATION.

The majority of the indicators in the evaluation framework were found to be appropriate. Together, the indicators capture the principal outcomes which the 1992 strategy was designed to achieve. Issues or questions remain regarding some of the indicators and will be addressed by a task force of USAID and CA representatives that will meet in May 1995.[1]

Monitoring and Evaluation Plan. There is a strong interest in and commitment to evaluating and documenting this program's achievements. Nonetheless, as the strategy arrives at its mid-point, important gaps remain in the information systems needed to allow effective evaluation. The gaps reflect a need to clearly designate responsibilities for developing and managing the program's monitoring and evaluation systems, and set firm schedules for completion of the

1 Since this report was drafted, the task force met and revised the strategic objective evaluation framework. The updated framework is attached to this report as Appendix E.

system's development. A number of measurements for baseline indicators are missing and targets have not been specified. A complete monitoring plan is needed which would specify how data will be collected and when; who will be responsible for collecting data; to whom data will be reported; and the timing of reporting. Also unresolved is where the locus of responsibility for managing the monitoring system should lie.

Documentation of Impact. Documentation of program impact under the Brazil population strategy has been largely limited thus far to establishment of baseline data. Some of the principal sources of baseline data are the 1991 DHS for the Northeast, and 1993/94 Situation Analyses in Bahia and Ceará states. Individual cooperating agencies are also developing baselines for future documentation of impact.

QUALITY OF CARE

Improvements in Quality of Care through Program Functional Areas. The current USAID population strategy in Brazil strives to improve the quality of family planning services to poorly served populations in the two Northeastern states of Ceará and Bahia by providing assistance in five key program functional areas: training; IEC; management; commodities and logistics; and research and evaluation.

Training. USAID has provided substantial support to training over the years and those investments have paid off in terms of a cadre of family planning/reproductive health professionals who are playing a leadership role in Brazil today. Much of this training has been in-service training. Of the five functional areas targeted for support in the current strategy, training has made the greatest accomplishments and is nearest institutionalization. By 1997, in both target states RH service delivery guidelines will be in place, sufficient RH training centers for training of physician and nurse providers will have been established, and sufficient trainers of physician and nurse providers will have been trained. In Bahia, specifically, training capacity will be partially in place to meet not only general RH training needs but also those of adolescents.

Management. Management has been one of the least emphasized of the five functional areas during the current assistance period. By 1997 most of the progress in the management area is expected to center around implementation of operational plans, and improvements in MIS, evaluation and logistics systems, with greater progress in Bahia than in Ceará. These systems will be operational but not fully institutionalized by 1997, and will require continued assistance to be sustainable by 2000. Management TA and training need to be emphasized immediately to assure that support systems are in place after the phase out period.

IEC. Progress in IEC has been slow during the phase-out period. Activities have been narrowly focused, primarily on developing basic communication skills and training providers in interpersonal communication and counseling (IPC/C). Production of new materials has been slow in getting under way, and stocks of materials produced before the phase-out are low. Current resources are insufficient for production and distribution of new materials. By 1997, IPC/C is expected to be incorporated into all RH training for physician and nurses, limited client IEC materials will have been produced and selected IEC materials for providers should be available. However, broader and more concerted IEC efforts are needed.

Commodities/logistics. Among the important changes that have occurred since the phase-out was designed are increasing demand for methods, growing public sector involvement in the purchasing and distributing of methods, and new private-sector initiatives in method procurement which appear to be sustainable. As the flow of USAID-funded commodities declines, reliance on alternative systems will increase. These channels have potential but need careful nurturing now and beyond 1997. Public-sector capacity is still weak, especially on the logistics side and in terms of having the steady financing needed to keep the system going.

Research/evaluation. The 1991 DHS and 1993/4 Situation Analyses provide good baseline data for the phase-out. Additional research, completed or underway, will provide complementary information for evaluation. Beyond this, the flow of evaluation information is quite limited. Plans need to be made for additional DHS-type surveys and Situation Analyses in 1996/1997 and beyond; for more systematic generation of program monitoring and evaluation information at the state and municipal level; and to establish a system for gathering the information needed for USAID program indicators on a regular basis.

Improvements in Quality of Care and Their Relation to USAID Support. One of the two desired program outcomes of the USAID/Brazil strategy is to improve the quality of family planning care by expanding the range of methods available, improving the use of family planning methods, and increasing the dissemination of correct information about reproductive health in Northeast Brazil. The primary sources of data to evaluate improvements in these areas are DHS and Situation Analyses. Since, however, only baseline data are available from these surveys, the review team has had to rely on service data and information from CAs.

Method Diversification. Given the reliance of Brazilian women on oral contraceptives and sterilization, USAID's efforts to improve quality have been directed primarily toward expanding the range of methods available such that women have a choice in the selection of their contraceptive method. It is recognized, however, that prevalence of these two methods, particularly sterilization, may not be affected as women become increasingly able to choose from a wider range of methods. What is important is that the decision to use a specific method, such as sterilization, be an informed one and not one made for lack of other contraceptive options.

USAID assistance can be directly linked to improvements in the availability of methods. In most service sites where USAID has supported training of providers in both states, the range of methods available has notably increased. Service data show an increasing tendency in the use of low-prevalence methods, particularly the IUD. The recent round of the Ceará MCH survey (PESMIC), on the other hand, shows a significant increase in sterilization from 1990 to 1994, while pill use decreased. Condom and IUD use increased considerably, but are still low. The survey was conducted in 1994, only one year into the current USAID assistance period.

Improved Method Use and Wider Availability of RH Information. DHS and Situational Analyses are the main sources of data on method use and availability of RH information. Since second rounds of both surveys are to be conducted later in the assistance period, no data are yet available to document improvement in this area.

SUSTAINABILITY

Sustainability is a priority objective for USAID assistance in Brazil. This objective focuses on strengthening of service delivery systems in the public, private and NGO sectors and not necessarily on the sustainability of specific institutions. Assistance to institutions will be determined by their contribution to the overall sustainability of a sector. Sustainability of service delivery systems is defined as: 1) full assumption of responsibility for the costs and implementation of family planning services by state and local health facilities in project sites; 2) replacement of USAID-donated contraceptives with a reliable alternative supply system; and 3) financial viability of NGOs supported through the strategy to continue without USAID funding or USAID commodities assistance.

Public Sector. In 1993 USAID began to target assistance to the public sector for implementation of reproductive health services. Several USAID CAs support this effort by providing contraceptives, training, technical support on IEC and technical assistance for strategic and operational planning. Evaluation and monitoring assistance have also been made available

State-level programs in Ceará and Bahia have made substantial progress over the last three years, mainly in setting up institutional mechanisms at the state level and mobilizing high-level political support for family planning/reproductive health. At the same time, the political and financial bases for these activities are still fragile, particularly in municipalities, which will have increasing responsibility for service delivery. UNFPA is assisting Ceará and intends to add one other state. Some funding is available through the World Bank's NE Basic Health project.

Given the time required to start activities, the slower nature of public sector implementation compared to NGOs, and the importance of building political commitment at the state and municipal level, service delivery systems are not expected to be entirely sustainable by 1997 and technical assistance will be required for specific functions through 1999. Areas of particular concern with regard to sustainability are: financing of key activities (training, IEC, commodities), institutionalization of these activities within the organizational structure of state and municipal health secretariats; integration of service delivery within the mainstream of primary health care; training of all types (from managers to community health workers [CHWs]); contraceptive availability and contraceptive logistics systems.

Political support and commitment to family planning has increased at top levels of both the federal and state governments. Understanding and interest in the reproductive health agenda is generally weak at the municipal level, however. Given the important role that municipalities are expected to play in the delivery of primary health care, much effort is needed to build stronger commitment to this agenda among local officials and their constituents.

Private Sector. The private health care sector in Brazil is responsible for providing a significant proportion of family planning services in the country, although pharmacies are the most significant private provider. The 1992 strategy team felt the private sector, which had been historically ignored by USAID, offered the potential to leverage USAID funds and help achieve service delivery and sustainability objectives proposed by USAID.

Progress in the private sector is mixed. Private-sector initiatives CEPEÓ and UNIMED, appear strong on financial sustainability. CEPEÓ, a commercial venture set up to establish a distribution mechanism for reasonably priced contraceptive methods, is already purchasing IUDs with its own capital. While it continues to underwrite key salaries with USAID funding, by the end of 1997 it is expected to be fully sustainable with no USAID funding. A joint venture with UNIMED (a medical cooperative similar to a HMO) established a hospital and diagnostic center that are expected to break even by late 1995. A MCH clinic is expected to open in May 1995 and become sustainable by October 1996.

The main issue with UNIMED is that it is not contributing to USAID's overall objective of using a private sector network to improve access to or expand family planning services. At the beginning of the venture, the CPR for UNIMED beneficiaries was much higher (75 percent) than for the general Maceio population (54 percent). The family planning service delivery mechanism under implementation to reach needier populations has not created a replicable model for integration of family planning services into the private sector, and UNIMED management and physicians are not particularly interested in family planning and not willing to serve low-income women.

NGOs. NGOs have been leaders in introducing family planning in Brazil. Although their role in direct delivery of family planning services has been limited compared to the public and commercial sectors, they have made contributions in training, IEC, supervision and contraceptive supply.

BEMFAM. An affiliate of the International Planned Parenthood Federation (IPPF), BEMFAM is the largest not-for-profit group active in reproductive health care. Much of BEMFAM's work is through contracts with state and municipal governments and business enterprises for provision of contraceptives, training, IEC materials and other services. In 1994, BEMFAM had 1,200 signed agreements, most with governments.

BEMFAM has relied heavily on USAID assistance. It now has a six-pronged strategy for increasing local income which includes: 1) introducing or including fees in its 11 clinics; 2) renegotiating payments received from municipalities for "services" rendered; 3) increasing agreements and net revenue from three labs; 4) launching a commercial condom venture; 5) selling IUDs; and 6) reducing headquarter costs.

BEMFAM's sustainability plans envision recovery of about 52 percent of costs by 1997. This figure is based on continued payments by municipalities for "services" rendered (in lieu of direct payment for donated contraceptives, which is prohibited) and does not include an imputed cost for methods (which would have to be purchased after 1997). In view of these factors and the likelihood that states will want to substitute their own purchasing arrangements, the 52 percent figure appears to be unrealistic. BEMFAM's strongest assets are its clinics; however, they are the least sustainable element of its program.

Pathfinder-supported Institutions and Activities. Pathfinder has been providing support to family planning programs in Brazil since the late 1970s. The fact that the Bahia State Secretariat of Health (SESAB) is now implementing reproductive health services is largely due to Pathfinder's on-going technical and financial support.

The most significant activities that Pathfinder supports are well along the continuum toward sustainability. The SESAB MIS and contraceptives logistics systems, designed and managed by Pathfinder, are in the process of being decentralized, although they are not expected to be entirely institutionalized by 1997 and will require some outside assistance thereafter. PP/PA family planning services are well on their way to becoming institutionalized in Bahia and will probably not require outside support after 1997. Institutionalization of these services has been less successful in other northeastern states, including Ceará. Pathfinder's function as a distributor of commodities is in the process of being transferred to CEPEÓ. Maintaining low prices will be key to assuring a sustainable supply of contraceptives to NGOs that currently rely on Pathfinder for commodities. A new sustainable information dissemination vehicle, as an alternative to *Planejamento Agora,* needs to be identified.

CONTINUED VALIDITY OF THE PHASE-OUT STRATEGY

USAID's decision to focus its population assistance during the Brazil phase-out on a few issues (sustainability, quality of services, public/private roles), a few activities to address those issues (training, IEC, commodities, investments in for-profit activities, and research/evaluation), and in two states (Ceará and Bahia) of Brazil's poorer Northeastern region was a sound one. The basic underpinnings of the strategy thus remain valid.

At the same time, some rethinking of the strategy is called for in reference to the time frame of phase-out activities, priorities among the different elements of the strategy, and opportunities to take advantage of changes in the policy and program environment. Macro-economic constraints have and are likely to continue to limit the capacity of states to allocate adequate financial support to public-sector reproductive health services. The private for-profit sector continues to play an important role in health service delivery, including family planning. However, the goal of leveraging support of private commercial activities to stimulate a broader method mix and cross-subsidize services for low-income groups has proved elusive. Some re-thinking of this aspect of the strategy is needed.

SUMMARY OF RECOMMENDATIONS

Recommendations for Functional Areas to be Strengthened and/or Specific Activities to be Undertaken to Assure Effective Phase-Out

Training

1. To meet the training needs that have been identified above, it would be useful to have someone step back and conduct an informal inventory of training investments up to now (who was trained, in what, and where they are now) and to identify specific gaps that need to be addressed. During the remainder of the phase-out period, USAID should recognize the critical role of preservice training and seek opportunities to address preservice training and in-service TOT. TOT courses for trainers of auxiliary nurses and CHWs should be implemented. The current effort to design and disseminate state-level guidelines needs to take account of federal regulatory mandates in this realm.

Management

2. Attention should be given to improving financial management and administration capabilities of state and municipal-level health council staff who are now responsible for planning, budgeting, and monitoring their own health system. Management training is needed in logistics management, financial planning, human resources development, and in design and use of information systems. Municipal officials also need assistance in dealing with changes arising from the health care reform process.

IEC

3. IEC material production should be accelerated to replace stock that are rapidly becoming depleted. Attention should be given to materials that provide information to users (actual and potential) and providers about alternative methods to the pill and sterilization, and about correct use of the pill. IPC/C TOT should be expanded to include auxiliary nurses and CHWs. Policy communications efforts are also needed to inform municipal officials of the importance of family planning and reproductive health services to their communities. Demand-generating activities should also be implemented as appropriate. Given the limitations on USAID funding, coordination with other donors (UNFPA and the World Bank) and the PAISM unit in MOH is needed to achieve these IEC objectives. IEC for users and providers of new methods will not be effective unless those methods are available, so that financing, management, and logistics issues need to be addressed in tandem with IEC efforts.

Commodities/Logistics

4. Emerging public-sector involvement in the forecasting, procurement, tracking and distribution of contraceptive methods urgently needs to be strengthened. Brazil's essential medicines program is functioning but weak; still, it has successfully distributed vaccines

nationally even under very difficult circumstances. Adequate financing is required (IEC, policy dialogue could help) as well as training in logistics and procurement procedures. This functional area should receive high priority attention.

Evaluation/Research

5. This area should also be strengthened. A full monitoring and evaluation plan for the program should be completed, and procedures for regular reporting established. Baseline and target levels need to be established for all indicators in the evaluation framework. CAs' activities need to be integrated more fully into the monitoring and evaluation plan. Roles and responsibilities for managing the program's information system should be clearly established. Plans need to be made for the next DHS survey, so that another round of population-based data will be available for 1996-97. Broader institutional participation in the next DHS round should be explored. The situation analysis research program should be continued.

Private Sector

6. CEPEÓ has strong potential to contribute to sustainability and quality goals in other functional areas and institutions. This potential should be encouraged by investment of additional resources during the phase-out period, if necessary. On the other hand, the strategy for increasing access to and expanding family planning services among underserved groups via the HMO sector (UNIMED) has not been successful. Consideration should be given to how resources invested in UNIMED can be freed and applied to activities that are more likely to contribute to USAID's strategic objective. Based on other priority needs, the time required to undertake new initiatives, the short phase-out timeline and limited resources available, other private sector ventures should not be pursued during the phase-out period.

7. As money tied up in the UNIMED investment in Alagoas is recovered, it might be used to establish a trust fund to support reproductive health activities as USAID assistance is phased out. Delineation of the range of activities covered by such a fund is beyond the scope of this report; however it is the view of the team that this use of the remaining funds would contribute more to USAID's phase-out objectives than continuing with the relationship with UNIMED or trying at this late stage to find some alternative for-profit health service investment opportunity.

NGO Sector

8. Major changes in the management and organizational approach of BEMFAM are needed to put the institution on a path toward sustainability: restructuring and decentralization of management, down-sizing of the Rio office, closing of clinics that do not break even, aggressive marketing of laboratory services in states where they are profitable, and development of a financial plan for phasing out USAID commodities. Without such changes, further funding will only prolong an inevitable funding crisis in 1997. If BEMFAM

will commit itself to these changes, USAID should continue funding BEMFAM; if not, USAID should withdraw funding and apply the resources to other needed investments. USAID should be prepared to support BEMFAM in this final effort to become sustainable through training of managers in such areas as marketing, pricing and cost containment.

Recommendations for Changes in the Current Phase-out Plan and Priorities in Case of Accelerated Phase-Out

Overall Objectives

9. The two central objectives of the phase-out strategy, sustainability and quality care, should be maintained, as well as the regional focus on the Northeast in the two states of Bahia and Ceará. Selected national-level activities should also continue, though with greater emphasis on actions to improve public-sector capacity in key areas (management, commodities, training, IEC) that relate to the sustainability and quality of services to groups who rely on the public sector for services.

Priorities

10. Public sector assistance should continue, though with greater emphasis on actions to improve capacity and institutionalize activities in key functional areas (management, commodities, training and IEC). Efforts to enhance private sector involvement in family planning should continue, although with less priority, and not through investments in HMOs. Public-private partnerships should be promoted.

Specific Recommendations

11. Give top priority to improving public sector financial and managerial capacity to supply contraceptives and other reproductive health pharmaceuticals and implement decentralized service delivery systems.

12. Continue to build public sector in-service TOT capacity for physician and nurse training, while increasing emphasis on TOT capacity for auxiliary nurses and CHWs.

13. Explore preservice training opportunities in schools of medicine and nursing in the target states, building on previous USAID investments in this area.

14. Broaden IEC efforts: accelerate production of IEC materials; implement demand-generating activities (i.e. mass media campaigns); focus on all target audiences (current users, potential users, providers and municipal officials); continue with TOT in IPC/C and building of IEC staff communication skills.

15. Complete the evaluation framework immediately, as well as the monitoring and evaluation plan, and implement monitoring systems.

16. Support a DHS in 1996, leveraging resources from other donors, and situation analyses in 1996/97.

17. Assure that all activities, particularly those involving training, IEC and commodities, are clearly designed and carried out to become institutionalized within the organizational structure of the public sector.

18. Disseminate information about QOC and assure that activities to improve QOC focus as a whole on all contraceptive methods.

19. Withdraw funding from BEMFAM unless profound managerial and organizational changes designed to increases its chances of being sustainable by 1997 are implemented within six months.

20. Negotiate withdrawal from the UNIMED venture, striving for recovery of the original investment adjusted for inflation and opportunity cost.

21. Continue support for the CEPEÓ, increasing support if necessary to assure a sustainable source of reasonably priced contraceptives upon USAID phase-out.

22. Make no further investments in the private sector unless they contribute to USAID's strategic objective.

23. Establish a trust fund, with funds divested from the UNIMED venture, to be used to support public-private partnerships as USAID funding is withdrawn and beyond.

24. Plan for continued support to the public sector after 1997 for specific activities in a limited number of functional areas, particularly contraceptive logistics, management and preservice training for medical and nursing students. Technical assistance with TOT training for specific provider groups (such as nurses) and for selected IEC activities will also probably be necessary.

Recommendation in the Event that Bilateral Assistance Becomes Possible

25. Because such a change would come relatively late in the phase-out process when resources have already been scaled down, direct involvement with the public sector would have to be very selective. It should focus on key needs such as commodity procurement and logistics. Policy dialogue could focus on such issues as service delivery guidelines, public/private partnerships, and trade and regulatory obstacles to imports of commodities or inputs for local manufacturing.

USAID-Supported Activities that Should Continue After 1997

26. The public sector will require continued technical assistance beyond 1997, particularly in the areas of management (including information systems) and contraceptive logistics.

Technical assistance with preservice training, TOT training for specific provider groups and for selected IEC activities will also likely be necessary.

Recommendations for the post-USAID Population Assistance Period

27. Efforts to strengthen reproductive health dimensions of HIV/AIDS prevention and youth projects during the remainder of the phase-out would help to continue focus on reproductive health after 1997. Policy dialogue on key issues such as public/private partnerships could also continue. Depending on the capacity of the USAID mission or of a CA such as Pathfinder that might continue to work in Brazil after 1997, it might be possible to promote involvement of U.S. private organizations in the post phase-out period.

28. The strategy calls for research and evaluation activities on overall program impact to be completed during the period 1998-2000. A national-level survey is an essential requirement for an adequate assessment of overall program impact. Such a survey should address other reproductive health issues in addition to fertility and family planning. It would be useful to set aside funds for a post phase-out review of overall impact and of lessons learned during the more than 20 years of USAID population assistance in Brazil.

29. The creation of a trust fund should also be considered to support targeted initiatives to continue private-sector assistance to the public sector during the post-assistance period.

What is USAID Leaving Behind after Phase-out?

USAID support has played an important and evolving role in the development of family planning in Brazil. During the 1970s and 1980s, USAID funding of non-governmental organizations helped to legitimize family planning in Brazil and establish mechanisms for service delivery through a variety of channels. Private providers have become increasingly important in the delivery of all health services in Brazil, and this is reflected in family planning and reproductive health. USAID-supported non-governmental organizations such as BEMFAM, SAMEAC, and PROPATER have provided training and IEC support, set standards, played an advocacy role, and helped to channel subsidized contraceptives to groups which have been poorly served by the private system. USAID-supported activities have also been at the cutting edge of efforts such as the move to broaden the method mix and improve the quality of services.

The 1990s have brought a renewed focus on the role of the public sector in the provision of health services, including family planning. For a variety of reasons, public-sector support of family planning did not materialize during the 1970s and 1980s. At the same time Brazil's new constitution guaranteed universal access to health services (including family planning) to the population, and the health reform movement in Brazil has been devolving responsibility for heath care service provision from previously highly centralized service-delivery structures at the federal level to the states and municipalities. Part of the growth in private-sector provision has been the result of uncertainties about the public sector's capacity to deliver on its commitment in the face of continuing financial and organizational challenges. At the same time, the expansion of private services has benefited mostly the middle- and upper-income

groups, and there is growing recognition in Brazil that the main role for the state is likely to be ensuring access to services for the low-income population, which is poorly served by both the public and private sectors.

The fact that this transition is occurring at the same time that USAID is phasing out population activities in Brazil poses some special challenges from the point of view of ensuring that USAID's earlier investments continue to have an impact after the phase-out is completed. From USAID's perspective, the most effective contribution to the successful outcome of this transition is likely to occur through public-private collaboration and utilization by the public sector of the trained professionals and technical capacity in private institutions that USAID has helped to develop over the past two decades. Effective public-private partnerships are essential to both objectives of the USAID phase-out strategy, that is, improved quality of services and sustainability (because improvement in the quality of publicly provided services is not likely to occur without the help of private-sector experience and expertise); and for organizations which USAID has funded over the years to find alternative sources of funding through subcontracting for activities such as training and IEC, or through reimbursement schemes for provision of services in order to achieve sustainability.

1 INTRODUCTION

1.1 Country Background

1.1.1 Demographic and Socioeconomic Overview

Brazil is an advanced developing country in terms of its demographic and socioeconomic indicators, though it is also characterized by marked differentials in these indicators among regions and social classes. Brazil has one of the ten largest economies in the world, with a per capita income approaching US$3000. Population growth has slowed substantially, reflecting the rapid fertility decline that occurred between 1965 and 1990. At the national level, total fertility is now estimated to be about 2.8 and contraceptive prevalence close to 70 percent. Improvements in health, including reproductive health, have generally lagged behind advances in other social sectors. Maternal mortality, for example, is estimated at 200 per 100,000 live births.

Northeastern Brazil, with a population of over 40 million (about 30 percent of the national total) continues to lag behind the rest of the country in terms of social indicators, although the pace of social and economic progress appears to be accelerating. According to the 1991 demographic and health survey (DHS), the Northeast infant mortality rate stood at 93.6, with higher levels in rural areas. The total fertility rate has declined, but was still higher (at 3.7 in urban areas and 5.2 in rural areas) than the rest of Brazil. The Northeast's contraceptive prevalence rate was 59 percent in 1991, which was still below the national figure of 65 percent in 1986.

While awareness of the existence of contraceptive methods is almost universal, actual use remains concentrated in two methods: female sterilization and the birth control pill. Poor use of pills has contributed to continued widespread abortion and to demands on the health system for treatment of incomplete induced abortions. Some progress has been made in broadening the method mix (more use of IUDs, condoms, and diaphragms) but much effort is still required, especially in rural areas, where 35 percent of the Northeastern population still resides.

1.1.2 Organization of the Health Sector

Over the past decade the Brazilian government has implemented a massive institutional, organizational, and financial reform of the public health care sector (Reforma Sanitária). The reform has three main objectives:

- Shifting responsibility for health care provision from the central government to municipalities
- Consolidating public service provision and finance
- Improving the equity of access to health services

Recent unrelated changes in public financing have left the health sector dependent on uncertain general revenues. A recent World Bank report (from which this summary is derived) discusses these issues in detail. That report addresses controlling health care costs, improving quality of care (QOC), and regulating health care--key issues in the implementation of health care reform.

The Brazilian health system differs from those in other developing countries. It relies heavily on public reimbursement of privately provided services to deliver care. Only a small portion of care, mainly for lower income groups, is extended through public facilities. Under the Single Health System (Sistema Unico de Saúde -- SUS), each state is expected to constitute a single "system" and be responsible for its own municipal and state services. Besides changing the relative power of different agencies, this arrangement requires much larger financial transfers to states and municipalities than before.

Although not yet fully in place, SUS faces some profound difficulties. Some are a legacy of the reform, but others are existing problems left untouched by the reform process. The 1988 Constitution, with its open-ended commitment to free public health care for all, combined with ongoing budgetary crises, has made it very difficult for states and municipalities to meet their new health care responsibilities.

1.1.3 Evolution of Family Planning

Family planning service delivery in Brazil has evolved differently from countries with organized national family planning programs. A disjointed mix of access channels has led to high prevalence put poor service quality and a narrow method mix in which the pill and sterilization predominate. Most Brazilian pill users acquire them at pharmacies. Sterilizations are performed in public as well as private facilities, and are generally done in conjunction with a Cesarean section birth, which enables them to qualify for reimbursement under public and private health plans. This also provides a "cover" for the procedure, which still has ambiguous legal status.

NGO involvement in direct delivery of family planning services has been limited, though NGOs have played an important role in training and information, education, and communication (IEC), along with working through contracts (convênios) with corporations and municipalities to provide contraceptives, training, and other services. Under SUS, states and municipalities are responsible for implementation of the Integral Woman's Health Care Program (PAISM) that was prepared during the 1980s in response to concerns about distortions in the family planning sector. Startup on PAISM has been very slow owing to the problems with SUS mentioned above, and because of weak political commitment to women's health, including family planning. Implementation of PAISM has moved ahead in some states in the South, for example in Sao Paulo. In the Northeast, the public sector has played a somewhat greater role in family planning service delivery, and two states (Ceará and Bahia) have recently accelerated implementation of PAISM.

1.2 Program Background

1.2.1 USAID/Brazil Population Assistance

In the 1960s and 1970s, Brazil was a major recipient of U.S. bilateral aid, including population assistance. Since 1983, direct assistance to the government of Brazil has been prohibited because of outstanding debt and nuclear non-proliferation issues. USAID has, however, continued to provide population assistance to the PVO sector, and in FY 1993 began assisting the commercial private sector in the provision of family planning services. Both the debt and nuclear issues appear to be nearing resolution, which could open the way for bilateral agreements and/or direct assistance to the Government of Brazil (GOB) if appropriate.

From 1988 to 1994, USAID has provided nearly US$50 million in population assistance to Brazil (see Figure 1). This support has contributed to increased availability of services, to expansion of the range of methods, and to provision of training and technical support for IEC. Activities have been directed at improving the QOC in both public and private provision of services, and toward ensuring that services continue when USAID support ends.

Figure 1

USAID also supports significant HIV/AIDS prevention programs in Brazil, concentrating in the southern states of Rio and Sao Paulo, where 70 percent of cases have been reported. There have been modest AIDS prevention activities supported by USAID in the Northeast, including a number implemented by family planning organizations. USAID is also providing support to NGO and governmental programs for at-risk youth (street children) ages eight to 17 in three major Northeastern cities: Salvador, Recife, and Fortaleza.

Other donors are supporting family planning and reproductive health activities in Brazil. The UNFPA is in the middle of a five-year program, which includes support to MOH for nationwide distribution of commodities and to the Ceará State Secretariat of Health for implementation of PAISM. UNFPA is considering additional support for PAISM in at least one other Northeastern state. The World Bank's Northeast Basic Health Project has supported renovation and equipping of primary health facilities and selected municipalities. Project funds are also being used for training and IEC in reproductive health. The Bank has also initiated a large-scale AIDS control and prevention project, which includes procurement of condoms and a number of related reproductive health activities.

1.2.2 Current Population Assistance Strategy and Implementation Plan

USAID's population assistance to Brazil is being phased out over the period 1993 to 2000. The objectives of the assistance strategy for this period are to:

- Improve the quality of family planning programs in Brazil by expanding the limited range of methods available, improving the use of methods, and increasing the information available about reproductive health.

- Ensure that there are viable service delivery systems in target areas when USAID assistance ends by working with states and the private sector to promote sustainability.

- Document the impact of USAID population assistance to Brazil through data collection and analysis at key points in program implementation.

Population assistance resources are being concentrated on the Northeast of Brazil, where the need to improve quality and sustainability is greater because of the region's poverty, population pressures, and poor reproductive health indicators. Two states (Bahia and Ceará) are the focus of that support. Their combined population is over 20 million. A limited number of activities are being carried out at the national level to increase private sector involvement and to address such issues as regulatory reform and adequate supply of contraceptive methods.

The strategy is being implemented through USAID's network of cooperating agencies (CAs) and their Brazilian counterparts with a restricted focus on provision of specialized technical assistance in areas of policy, training, IEC, social marketing, commercial sector involvement in family planning and commodities procurement, logistics management, research and evaluation. The implementation plan anticipates that most of the activities related to service delivery will conclude by 1997, leaving the final years for data collection and impact evaluation.

1.3 The Assessment

1.3.1 Purpose of the Assessment

The objectives of USAID's population assistance strategy are to improve program quality and promote sustainability of family planning services. The purpose of this assessment is to examine progress toward these objectives and to consider whether the objectives can be achieved within the planned phase-out period.

1.3.2 Methodology

A mid-term assessment of the strategy was called for in early 1995 to examine progress to date and to advise on priority actions within the remaining phase-out period in light of new directions at USAID and changes in the policy and program environment in Brazil, and to recommend mid-course modifications in the strategy and/or implementation plan if needed. The assessment team was composed of Tom Merrick (team leader), Karen Anderson (evaluation/indicators), Karen Johnson Lassner (planning and program management), Maria Busquets-Moura (training/management/IEC), and Wyman Stone (procurement/logistics).

The team conducted interviews and reviewed relevant documents in Washington, D.C., with staff of USAID's Office of Population, Office of Health, and the Bureau for Latin America and the Caribbean, and in Brasilia with staff of the USAID Mission. All five team members traveled to Brazil, where they met with staff from the public- and private-sector agencies involved in implementation of the strategy. During the visit, a one-day meeting was held with CAs working in Brazil to discuss their strategic approaches and progress in achieving the overall objectives of quality and sustainability. The terms of reference, itinerary, and contacts made by the team are presented in the appendices.

2 CHANGES IN THE POLICY AND PROGRAM ENVIRONMENT

2.1 The New Mandate for USAID's Population Program

The Brazil population assistance strategy predates the reorganization of USAID and the expansion of the mandate of its population program. The newly formed Center for Population, Health, and Nutrition (PHN) has prepared a draft strategic plan to guide USAID's global effort to reduce fertility, improve the health of women and children, and stem the spread of HIV and other STDs. The plan focuses on four strategic areas:

- Increased use of voluntary practices by women and men that contribute to fertility reduction.
- Increased use of reproductive health interventions with a focus on safe pregnancy and nutrition.
- Increased use of key child health interventions.
- increased use of interventions to reduce HIV/STD transmission and mitigate its impact.

The Brazil strategy anticipated the broader approach of USAID's global strategy with its emphasis on integrating family planning with other reproductive health activities. In Brazil, USAID's strategy also addresses HIV/AIDS prevention and management. A new program for at-risk urban youth also envisions a health component that will address such issues as teen pregnancy and high-risk sexual behaviors. Several of the family planning CAs and their Brazilian NGO partners are also working in these areas and are likely to continue to do so after USAID's population phase-out in 1997.

One aspect of USAID's global strategy that needs to be approached with care is its reference to the demographic objective of fertility reduction as a motive for family planning activities. There is a long history of opposition to what Brazilian reproductive health advocates characterize as "controlismo" in family planning efforts funded by foreign agencies. They are perceived to be more interested in slowing Brazil's population growth than the reproductive health and rights of Brazilian women.

Given the advanced state of Brazil's demographic transition process and the progress that has been made in building consensus and support for family planning as a reproductive health intervention in Brazil, reference to demographic objectives is not appropriate and could jeopardize the improving but still fragile relationship between population CAs, their Brazilian NGO partners, and Brazilian reproductive health activists. As the discussion that follows will illustrate, much needs to be done to turn Brazil's new commitment to reproductive health into effective action; nonetheless, the new policy direction that was described in tentative terms when USAID's Brazil strategy was developed has grown stronger and is consistent with most of the Agency's global PHN mandate.

2.2 Brazilian Responses to the ICPD Program of Action

Brazil played a major role in the lead-up to the Cairo International Conference on Population and Development (ICPD). Brazilian women's reproductive health and rights groups were among the first to call for reorientation of population policies toward individual health and welfare, beginning with their participation in the UN Conference on Environment and Development (UNCED) in Rio in 1992. Brazilian representatives also played a pivotal role during ICPD PrepComs in redrafting the Cairo Program of Action to reflect this new vision of population.

At Cairo the Brazilian delegation held the line while under considerable pressure from the Vatican and other Latin American delegations to join in the effort to dilute the sections of the Program of Action relating to reproductive health. There is widespread support among women's health advocates in Brazil for the ICPD Program of Action. There is also a growing recognition that the momentum of Cairo will be lost without concerted effort to implement the reproductive health service and information package called for but not yet functioning on a national scale under the PAISM program.

An important issue that is attracting attention in many quarters of the Brazilian reproductive health and family planning community is the "Projeto de Lei" on family planning that was passed in June 1994 by the Camara dos Deputados. This legislation has been under discussion for some time. One of its main goals is to correct the problems associated with the ambiguous legal status of surgical sterilization in Brazil. It is also meant to translate into law the provisions regarding family planning in Brazil's 1988 Constitution. The bill is now up for consideration by the Brazilian Senate.

A provision of the proposed legislation gives SUS management control over financing of family planning research and service delivery by foreign donors. This is viewed with great alarm by Brazilian NGOs such as BEMFAM, who see it as a not-so-thinly veiled attempt to put them out of business. The legislation has strong support among women's health advocates who see it as the culmination of their efforts to "fiscalize" Brazil's family planning movement. When queried about this and other provisions of the law that appear to be at odds with women's reproductive rights (e.g. the requirement of a husband's consent for sterilization), some advocates replied that these deficiencies could be amended later; others simply reminded us that the law was needed to put an end to the "mass sterilization of Brazilian women that was being subsidized by foreign population control agencies" (from *Femea*, June 1994, p. 2).

2.3 The Cardoso Government and the Plano Real

Brazil's new President, Fernando Henrique Cardoso, took office earlier this year. Cardoso had a distinguished academic and activist career before going into politics, and played a key role in putting Brazil's economic stabilization plan (the Plano Real) into place during his tenure as Finance Minister in the previous administration. Cardoso is strongly committed to social programs, and his spouse, Ruth Cardoso, has been a leading advocate of women's rights in Brazil. Many in the reproductive health community have great hope that PAISM will flourish during the Cardoso Administration, although they also recognize that Cardoso has no choice but to put highest priority on the economic stabilization program.

Previous stabilization efforts have contributed to the financial difficulties of SUS and have limited the resources available for PAISM in states and municipalities. One effect of the removal of price controls on pharmaceuticals under stabilization was to raise the retail price of birth control pills tenfold. There was general agreement that full implementation of PAISM will not occur without improvement of the management of financial and human resources at all levels (federal, state, and municipal) of the SUS system. Most observers agreed that it was still too early to draw firm conclusions about the likelihood of this happening. Views ranged from extreme skepticism on the part of traditional family planning providers to cautious optimism among reproductive health advocates.

3 PROGRAM EVALUATION PLAN

3.1 Evaluation Framework and Indicators

The population strategy and implementation plan for Brazil call for development of an evaluation plan to permit assessment of the program's achievement of its objectives. With the assistance of the EVALUATION Project, an evaluation framework was developed that combines the elements of the USAID PRISM strategic objective methodology with an approach developed by the EVALUATION Project (see Appendix C). The USAID methodology calls for articulation of a program "objective tree", consisting of a *strategic objective*, to be achieved in five to eight years through the accomplishment of one or more lower-level *program outcomes*, which in turn are to be achieved through program activities. The EVALUATION Project approach varies from the PRISM system by adding *specific results* that define the strategic objective and each program outcome, and by developing indicators of measurement at the program outcome level which are divided into measures of *program outputs* and of subsequent *population outcomes*. While this approach is more complex than the usual PRISM monitoring plan, it has two advantages: 1) the specific results provide further clarification of the strategy; and 2) the emphasis on population outcomes enforces a focus on people-level results which may otherwise be overlooked.

As a result of a number of changes in the environment surrounding the strategy, and in response to the recommendations of the present assessment, elements of the USAID strategy may undergo revision or adjustment. Changes in the strategy will necessarily result in changes in the indicators. During the March 1995 CAs' meeting in Fortaleza, it was decided that a task force of CA and USAID representatives would review the indicators following any adjustments in the strategy that follow this assessment. (While a formally designated task force has not existed in the past, the EVALUATION Project has held a series of group and individual meetings with representatives of CAs working in Brazil to define the current evaluation indicators.) It is probable, however, that significant parts of the strategy will remain the same. Hence, this section discusses the appropriateness of the existing indicators. The principal criteria applied to evaluate the appropriateness of the indicators were the following:

- Are the indicators direct measures of the strategic objective and program outcomes as defined in the specific results?
- Are they feasible measures in terms of apparent data availability?
- Are they precise measures, i.e. unidimensional and framed in operational terms?
- As a group, are they adequate to capture the most important aspects of the strategic objective or program outcome?

Measured against these criteria, the majority of the indicators in the evaluation framework were found to be appropriate. (Please refer to Appendix C for a list of the indicators.) Together, the indicators capture the principal outcomes which the 1992 strategy was designed to achieve. (Please refer to Appendix D for a full discussion of indicators.)[2]

2 This discussion refers to indicators from the evaluation framework in Appendix C before it was revised.

3.2 Monitoring and Evaluation Plan

The time and resources devoted to development of the evaluation framework demonstrate that there is a strong interest in and commitment to evaluating and documenting this program's achievements. Nonetheless, as the strategy arrives at its mid-point, important gaps remain in the information systems needed to allow effective evaluation of the program impacts. While hardly unique among USAID programs, these gaps reflect a need to clearly designate responsibilities for developing and managing the program's monitoring and evaluation systems, and set firm schedules for completion of the system's development.

A complete monitoring and evaluation plan has not yet been developed for the program. Early in the strategy period, assistance was sought from the EVALUATION Project in developing an evaluation plan. The strategy's implementation plan called for development of a system for collecting the necessary data for program baselines as well as appropriate process and impact measurement. The implementation plan also called for a system for collecting the necessary data and a plan for impact analysis. The CAs were to be asked to develop evaluation plans along the same lines for their areas of assistance.

To date, the EVALUATION Project has worked with USAID and CAs to develop the evaluation framework. This framework depicts the program objective tree, corresponding indicators and data sources. The EVALUATION Project has also provided assistance to the program in analyzing data from the DHS and the Ceará situational analysis to provide baseline levels for 16 of the 36 indicators in the framework. This work is still in progress. The rest of the baseline data, as well as target levels for all indicators, are still missing. Procedures for reporting and a reporting schedule have not been established for those indicators for which CAs or NGOs are to provide data. None of the CAs have yet reported data for the framework.

Hence, the program still lacks a complete monitoring plan which would specify how data will be collected and when; who will be responsible for collecting data; to whom data will be reported; and the timing of reporting. Also unresolved is where the locus of responsibility for managing the monitoring system should lie. A January 1993 EVALUATION Project report noted this as an outstanding issue and explored various alternatives for allocating responsibility. Suggested alternatives included assigning responsibility for management to the EVALUATION Project, either under existing funds or an additional buy-in, a Michigan Fellow or a local NGO.

The USAID program has faced major constraints in managing its monitoring and evaluation activities effectively. First, USAID/Brazil's small staff has extremely limited time available for development and management of the information system. Second, because the population activities are centrally funded, arrangements call for the CAs to report their service statistics directly to USAID/Washington. These data are generally not disaggregated by country and do not coincide with the more impact-level data needed for the evaluation framework.

3.3 Documentation of Impact

Documentation of program impact under the Brazil population strategy has been largely limited to establishment of baseline data thus far. Some of the principal sources of baseline data which have been established include the 1991 DHS for the Northeast, and situational analyses in Bahia and

Ceará states, which will be discussed in Section 4.1.5. The PESMIC (Pesquisas de Saude Materno-Infantil do Ceará) studies, carried out in Ceará in 1987, 1990, and 1994, provide an additional source of data on maternal-child health, including some family planning information. The Continuous Monitoring and Evaluation System (SISMAC) information system set up with Pathfinder assistance for the Bahia State Secretariat of Health (SESAB) in Bahia, and the information system currently being designed for the Viva Mulher program in Ceará, will provide additional data sources on service delivery and family planning method use.

Individual CAs are also developing baselines for future documentation of impact. For example, Pathfinder is currently completing a survey of client satisfaction and service delivery in 61 health units in Bahia; it plans to update this survey in late 1996. The Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO) is developing data to determine the impact of its training services on provision of IUDs. However, most CAs are concentrating on collection of service statistics rather than impact data. Couple years of protection (CYPs) are the closest approximation to an impact measure in current use by CAs.

3.4 Future Priorities

In the evaluation framework, the USAID program possesses a well-articulated outline of its current strategy. A number of critical gaps exist, however, which must be addressed to complete the framework and establish systems to support it. Related to this theme, the team offers a number of recommendations regarding the program's overall research and evaluation agenda in Section 4.1.5.

3.4.1 Completing the Monitoring and Evaluation Plan

As discussed above, USAID/Brazil plans to review the strategy following completion of this assessment. After that, the indicators will be reviewed by the CA task force and a USAID representative. High priority should be placed on refining the indicators and completing the process of establishing baseline levels for each indicator. In some cases, establishing baseline levels will require further assistance from the EVALUATION Project in developing the needed data from the DHS and situational analyses. Targets for each indicator should be developed collaboratively by the CAs and USAID.

As part of the process of completing the monitoring and evaluation framework, USAID needs to reach agreement with the CAs regarding procedures for reporting data. The complete monitoring and evaluation plan should clearly define the roles, responsibilities and schedules necessary for data gathering and reporting. Among other purposes, the monitoring plan will:

- Identify data sources for each indicator.
- Describe the methodology used to collect the data, so that it can be repeated.
- Set periodicity of reporting.
- Identify the organization, and where feasible, the individual responsible for actually reporting data.
- Identify the person and organization responsible for receiving the data.

The results should be formalized in a written monitoring and evaluation plan.

The task force composed of a few CA representatives appears to offer a good vehicle for reaching agreement with CAs regarding reporting processes. Despite the large number of indicators included in the evaluation framework, reporting should be less onerous for CAs than it may appear because a large number of the indicators are based on DHS and situational analysis data. There are only nine indicators in the current framework which require CA input. To keep the system running smoothly and sustain CA involvement, the task force should meet more frequently than in the past and work on special issues which arise, such as definition of QOC and client satisfaction score indicators. If it is impractical for a USAID/Brazil representative to attend task force meetings, a representative from Global/PHN could represent USAID, maintaining feedback with USAID/Brazil.

Given the slippages experienced in completing the monitoring plan so far, the team recommends that USAID set firm schedules for each step of completing the monitoring plan and establishing reporting systems.

3.4.2 Management of Data Collection Systems

Overall responsibility for management of the system must be clarified. The program needs to identify who will be responsible for refining the evaluation framework and indicators when needed, keeping the monitoring and evaluation plan updated, analyzing the data provided, overseeing the analysis, coordinating reporting of data from the CAs, and maintaining a database.

Assigning responsibility for management of the strategy's information system to Mission staff is the most desirable alternative, because it ensures that the Mission is directly involved in coordinating the data needed for program management. However, since time available to USAID/Brazil staff clearly seems inadequate, alternatives should be reviewed. Alternatives discussed in the past included assigning this role to the EVALUATION Project; to a Global/PHN fellow; or to a local NGO not currently involved in the strategy. An additional alternative would be to seek a local consultant or firm with expertise in family planning and information management to coordinate the system. Such a consultant or firm could be trained by the EVALUATION Project to familiarize them with the program and the methodologies being used. This option would offer the advantage of creating local capacity that could be used to continue coordination of evaluation activities in the post-phase-out 1997-2000 period. As discussed above, the CA/USAID task force should continue in order to provide essential input to the monitoring plan and to sustain the CAs' involvement and stake in the monitoring system. By designating a specific group or individual to be responsible for management of the system, the task force should be more effective than in the past.

3.4.3 Linkages with Cooperative Agency Reporting

A January 1993 report of the EVALUATION Project indicated that the Project had begun work with CAs to create a logical framework linking project activities with program outcomes and objectives. This work is not yet complete, and CAs' reporting systems do not seem to be oriented to reporting on impact.

The team recommends that the EVALUATION Project complete the task of working with CAs to link their evaluation plans with the overall program evaluation framework. This work should focus on establishing systems for documentation of impact, including tracking information that will permit

study of linkages between CAs' individual activities and larger-scale impacts that will be tracked through the situational analysis and DHS. Special evaluation studies may also be planned to document these linkages. This can be an important item to include among overall improvements in quality and sustainability to be attributed to USAID assistance. The EVALUATION Project has particular interest in tracking data to document the sustainability of systems for planning, training, and other areas established by the CAs. This seems another worthwhile area for gauging program impact.

4 QUALITY OF CARE

4.1 Strategic Approach to Improvements in Quality of Care

The current USAID population strategy in Brazil strives to improve the quality of family planning services to poorly served populations in the two Northeastern states of Ceará and Bahia by providing assistance in five key program functional areas: training; information, education and communication (IEC); management; commodities and logistics; and research and evaluation. The following sections describe the strategic approach in each of these functional areas, their current status, and areas that could be strengthened.

4.1.1 Training

The training strategy focuses on training family planning service providers to increase knowledge about the entire range of contraceptive methods available; reduce bias against certain long-term methods such as the IUD and injectables; and improve technical skills. Activities expected to help accomplish these objectives include training of public sector physicians, nurses and paraprofessionals in Ceará and Bahia; and development of reproductive health service guidelines and policy norms at the state level. Activities by state are reviewed below.

Ceará. The training strategy in Ceará focuses on improving the technical skills of physicians, nurses, paramedics, traditional birth attendants (TBAs), and community health workers (CHWs), standardizing training, and assisting in the development of reproductive health guidelines and norms. Between 1990 and 1995, over 400 service providers were trained by SAMEAC (the Federal University Maternity School) and JHPIEGO. In addition, training-of-trainer (TOT) courses were conducted for municipal and state health workers. By 1997 the following activities should be completed:

- Reproductive health service-delivery guidelines will have been revised, published, and distributed.
- In-service training curricula will be updated and consistent with the new guidelines.
- Specialized TOT courses in postpartum and postabortion family planning and in sexuality and adolescent reproductive health care will have been conducted.
- In-service training and TOT will be ongoing.

Bahia. The training strategy in Bahia focuses on the establishment of service delivery guidelines and norms, training of trainers and service providers in reproductive health, and the special needs of adolescents. JHPIEGO and Pathfinder have trained trainers and providers in reproductive health, reversible contraceptive methods such as the IUD, and postpartum and postabortion contraception. Development Associates has focused on training of low-literacy health workers.

Between 1993 and 1995, over 850 service providers were trained by Pathfinder, JHPIEGO, and SESAB. Twelve training centers were established and staffed by physician/nurse trainer teams. A memorandum of understanding was recently signed by SESAB, the Bahia State Secretariat of Education and Culture, and JHPIEGO to strengthen PH policy, training, and services in the state. By 1997 the following activities should be completed:

- Reproductive health guidelines will have been developed, published, and distributed.
- Standards for sexuality education will be developed, published, and distributed.
- Additional reproductive health trainers will be trained, some specifically geared towards adolescents.
- Adolescent reproductive health services will be established close to secondary schools with cross referral systems linking schools and service sites.
- Secondary school teachers will be trained to provide sexual education and motivational meetings will be held for school administrators and parent groups.

Several key activities in both states will need particular attention before and after 1997. Once state-wide service delivery guidelines and norms are completed (scheduled for early 1996), service providers with new responsibilities under the new guidelines will need in-service training. For example, the new guidelines are expected to permit nurses to provide IUDs and other reversible methods. Nurse clinical training will most likely need to continue beyond 1997. Two additional cadres of service providers, CHWs or "agentes de saude," and auxiliary nurses have received very little training in Ceará and no training in Bahia. Reproductive health training curricula need to be developed for these workers who number in the thousands. Emphasis on TOT will help ensure that appropriate training continues after 1997. Finally, work with adolescents should be approached with caution. This is a relatively new area for USAID and much needs to be learned. For example, a serious look should be given to the percentage of adolescents reached through the formal educational system; many young adults in these two northeastern states may not be in school.

4.1.2 Information, Education, and Communication

The strategic approach in IEC is aimed at improving QOC by better informing poorly served populations about different methods available and how to use them correctly; by improving communication between provider and client; and by developing the capacity to develop appropriate IEC materials and communication strategies.

Ceará. In Ceará, Viva Mulher's progress with IEC has been slow. In part, this may be due to poor coordination with the State Secretariat IEC unit which also conducts IEC activities. As a result, there is no clear statewide strategy for communication interventions. Some TOT has been conducted in interpersonal communication/counseling (IPC/C) training but there is no evidence it is being replicated to other levels.

Bahia. A key change in SESAB since 1992 is a better understanding, on the part of senior management, of the power of IEC, the importance of having an IEC strategy, and the role of the service provider as a communicator and key provider of information on all family planning methods. There has been a shift from quick turnaround production of unrelated materials to a strategic look at IEC which includes clear messages, target audiences, focus groups and pre-testing of materials. TOT in IPC/C is now integrated into the ongoing TOT curriculum.

By 1997, the IEC objectives in both states are to:

- Train physicians and nurses in interpersonal communications and counseling.
- Update existing IEC support materials (from the Associacao Brasileira de Entidades de Planejamento Familiar {ABEPF} and other institutions).
- Translate selected materials (e.g. population reports) into Portuguese.

While activities scheduled to take place by 1997 are important, and should continue as scheduled, the slow pace and narrow scope of IEC activities in both states is of great concern. The following areas merit special attention:

IEC material production. There is an enormous need for IEC materials in both states confirmed by team visits to service delivery points. Current USAID resources do not cover production or distribution of materials. Meetings should be scheduled with UNFPA and World Bank staff to coordinate funding in this area.

IPC/C. New IPC/C training curricula should be developed for auxiliaries and "agentes de saude" which often are the initial point of contact for current or potential family planning users. Curricula should be developed and incorporated into the general family planning and reproductive health curricula which need to be developed for these cadres (see Section 4.1.1 above on training). IPC/C TOT training conducted in Ceará needs follow-up and strengthening to ensure IPC/C TOT begins to produce first and second generation trainees.

Mass media campaigns. Full-scale demand creating mass media activities and campaigns at the community, state, and regional levels are not scheduled to begin until service delivery points are equipped with trained service providers, contraceptives are available, and logistical systems are operational. Unless these campaigns are accelerated there may not be adequate time to inform potential clients of the new quality services and methods available before 1997. Campaigns could be initiated in select health regions (DIRES/DERES) as appropriate. Resources need to be obtained to move forward in this area.

Target audiences. There are at least four separate target audiences for IEC activities: the current family planning user, the potential family planning user, the service provider (to reduce provider bias against underutilized methods), and policy makers at the municipal level. Activities should be restructured to ensure each of these audiences is reached.

4.1.3 Management

State and municipal authorities are now autonomous and not under the direct control and supervision of the MOH; they have the primary responsibility for implementing service delivery under the PAISM program. Improvement of statewide and municipal management systems and of management capacity and capability of state- and municipal-level program coordinators and their staff is important, not only for long-term sustainability, but also for improved QOC within the reproductive health delivery system. Yet, in practice, to date, management is one of the least emphasized of the five functional areas in the USAID strategy.

The two key management areas highlighted in the USAID strategy are training in management and administration for state and municipal-level managers with an emphasis on the integration of reproductive health programming and budgeting at the local level; and design of information systems together with strengthening the technical expertise to maintain them. Most of the technical assistance provided thus far has been in the area of strategic and operational planning, supervision, management information system (MIS) development, logistics and evaluation training.

Ceará. In Ceará, the development of a strategic plan proved to be a challenge for two primary reasons: a) the plan was produced after a large umbrella project proposal for the Viva Mulher Program was submitted to UNFPA for funding; subsequently, the official launching of the Viva Mulher project in 1994 diverted attention away from implementation of the strategic plan; and b) the State Secretariat Planning Division, which has access to essential information, particularly financial, did not participate in the planning process since it is opposed to "vertical" programs. As a result, there is no budget attached to the strategic plan. Two consultants are currently working with the Viva Mulher coordinator to summarize the strategic plan and streamline the objectives. Progress through 1997 is likely to center around operationalizing the strategic plan, and improving the MIS, evaluation and logistics systems.

Bahia. In Bahia, the development of a strategic plan built on lessons learned in Ceará. The Planning Division of the State Secretariat was included, methodology was simplified, and the development of an operational plan was built in as a quick follow-up to the macro vision presented in the strategic plan. A March 20, 1995 meeting was held in Bahia to present both the strategic and operational plans and discuss specific technical assistance (TA) needs, timelines, and budgetary allotments. It was attended by UNFPA, USAID and numerous USAID CAs. Most of the progress in the management area is expected to be in the implementation of the operational plan; and in improvements in the MIS, evaluation, and logistics systems. According to Pathfinder, these systems will not be fully institutionalized by 1997.

Overall, progress in the management area has been slow. Several key areas were not identified in the strategy document; activities that were identified have either not been given attention (management training for state and municipal-level managers), or are in the initial phases of implementation and should be accelerated. Some interventions should be revisited to ensure a strong foundation is being created on which to build sustainable systems.

The following areas are in need of particular attention:

Municipalization. In view of the significant autonomy and responsibility of state and municipal authorities, USAID assistance should be directed at helping the states decide who answers to whom, who has the authority to do what and who pays. In Ceará, where the municipalization process has progressed further, USAID assistance should build on or complement the technical assistance already provided by PAHO (mostly for municipal planning and budgeting). Bahia has not yet begun the process.

Work with municipal health councils. As part of the decentralization process, states will need to learn how to collaborate and work with municipal health councils who are now responsible for planning, budgeting, and monitoring their own health system. As USAID's strategy correctly recognizes, local leadership is now responsible for composing a single health system in each municipality, consisting of public institutions and contracted private institutions. Municipal capacity to

plan and operate health services in Bahia's 415 and Ceará's 183 municipalities varies immensely. USAID assistance should be directed to improving the management capacity and capability of state and municipal secretariat staff and municipal health council members. TOT would be a key component of this activity.

State secretariat strategic plans. These should define the roles and responsibilities of *all* key service delivery players in the state. An effective phase-out strategy needs to consider market segmentation, and coordination and linkages with NGOs and the private and commercial sector to create an effective and sustainable delivery system.

Technical assistance. USAID assistance in the areas of financial planning, human resource development, and MIS will contribute to the sustainability of services after the USAID phase-out. Expected results include budgetary line items for key activities (i.e., purchasing of contraceptives), decreased staffing shortages, which are currently exacerbated by the process of municipalization, and the use of the MIS as a tool for management decision-making.

4.1.4 Commodities and Logistics

In the two states where USAID has focused its assistance since 1992, family planning services would quickly dry up without USAID-subsidized commodities. The following factors influence contraceptive logistics and commodities decisions within Brazil as they relate to QOC:

- Oral contraceptives and condoms appear on the Brazilian list of medicines which the central government procures and distributes to states. However, the volume of procurements has been very limited to date.

- Bureaucratic obstacles at the federal level have hindered efforts to import condoms, which are far cheaper on the international market.

- SUS reimburses doctors for IUD insertions and diaphragm fittings at a rate less than the cost of purchasing the commodities.

- Oral contraceptives are available in pharmacies, though prices have increased substantially since they were decontrolled. These increases have followed the general trend of the Plano Real.

- Present Brazilian law remains unclear about the legality of female sterilization, which is performed during often unnecessary Cesarean births; legislation now before the Brazilian Senate allows sterilization for fertility regulation, but with many restrictions.

- The Brazilian women's health movement has serious reservations about non-governmental groups who provide contraceptives and has demanded that the government take responsibility for providing family planning and reproductive health services.

Most state and municipal governments face serious resource constraints. Some states and municipalities have begun to purchase contraceptives, although other priorities generally take

precedence over buying contraceptives with state or municipal funds. Distributing contraceptives presents a particular problem at the state and municipal level. Former federal warehouse operations in the states have been turned over to state governments. The limited quantities of contraceptives procured by the federal government or received at the federal level from international donors are shipped to state government-run warehouses. But state governments lack resources to distribute contraceptives reliably to outlying medical facilities. Moreover, frequent labor strikes by state employees often interrupt medical services to the public sector for extended periods.

In Ceará and Bahia, the state governments are developing family planning and reproductive health programs. USAID actively supports these efforts with a wide range of donated contraceptive commodities (see Table 1). The contraceptives are received and distributed by two USAID sponsored NGOs: BEMFAM and Pathfinder International. UNFPA also provides donated contraceptives in Ceará. In 1994, BEMFAM, the Brazilian IPPF affiliate, maintained 1,199 negotiated agreements (convenios), 85 percent of which were with state and municipal governments. Through these agreements BEMFAM distributes contraceptives primarily to public sector health posts. BEMFAM also distributes contraceptives through its own clinics in these two states, as well as in others. In 1994, BEMFAM received approximately US$75 million of donated contraceptives for 1,800 sites in 10 states. In 1994, Pathfinder distributed US$.74 million of donated contraceptives to approximately 200 NGOs and private recipients.

TABLE 1

VALUE OF USAID CONTRACEPTIVE DONATIONS TO BRAZIL 1990-1994

YEAR	IPPF	PATHFINDER	TOTAL
1990	603,014	185,772	788,786
1991	839,253	339,510	1,178,763
1992	311,989	390,108	702,097
1993	1,534,282	511,904	2,046,186
1994	749,998	737,934	1,487,932
TOTAL	$4,038,536	$2,165,228	$6,203,764

Source: NEWVERN Database and Pathfinder, Brazil

As of March 1995, Pathfinder has been transferring its inventory of contraceptives to a new commercial corporation created by the Promoting Financial Investments and Transfers Project (PROFIT). This corporation is called CEPEÓ (it is a contraceptive procurement organization set up to establish a distribution mechanism for reasonably priced contraceptive methods). Its purpose is to provide a continuing source of contraceptive commodities for previous Pathfinder clients. CEPEÓ will buy commodities on the international market and sell them at subsidized

prices to public sector and NGO clients. It also will sell commodities at reasonable market prices to private clients. The CEPEÓ is the only USAID sponsored entity dealing with logistics and commodities in Brazil that appears likely to become self sustaining by 1997.

At the government level, it is unlikely that a reliable supply system will be in place by 1997 to replace USAID-donated contraceptives. This prospect is disheartening because the government of Brazil has a proven capacity to provide a reliable national acquisition and distribution system for high visibility medicines. Polio vaccine is available throughout the nation. Also, the Brazilian government is now acting to procure and distribute 200,000,000 condoms for HIV/AIDS prevention over a five year period under the World Bank project. The procurement is being processed by the World Health Organization (WHO). Deliveries of these condoms apparently now clear Brazilian customs and testing in about three weeks.

Meanwhile, condoms being imported by a USAID supported social marketing program through DKT to Brazil often take over six months to be processed and tested by Brazilian authorities, even though they have been inspected and tested in country of origin as well as by Family Health International (FHI) in North Carolina before being shipped to Brazil. BEMFAM's donated condoms from USAID are suffering the same fate with delays of at least six months and lot rejection rates of up to 60 percent, even though they too have been inspected, tested, and approved by FHI in its North Carolina facility before being shipped to Brazil. BEMFAM currently has over seven million USAID donated condoms in its central warehouse in Rio, which it is unable to distribute because of Brazilian government delays in product testing. An additional 8.8 million USAID donated condoms are ready to ship from a USAID warehouse in Washington, D.C., but documents forwarded to the Brazilian government in October 1994 and January 1995 requesting clearance to ship to Brazil remain unprocessed in Brasilia.

The team believes that the federal government of Brazil could marshal the necessary resources to replace USAID donated commodities in Brazil. The GOB will need guidance and nurturing to overcome widespread political reticence in this area and to increase the chance of success for this undertaking. USAID/Brazil should continue to encourage GOB to maintain close links and an active interest in ongoing and projected World Bank, WHO, and UNFPA programs in Brazil. These programs, with careful planning, could increase the availability of contraceptives in Brazil. A dialogue on several key issues should be pursued, particularly in the event that bilateral relations with GOB become possible.

Recommendations:

Recommendation No. 1: USAID should seek to convince the national government that making contraceptives available to existing family planning service delivery points is a smart political move. This message could also emphasize the additional national health benefits possible if the government were to consolidate the HIV/AIDS condom procurement and distribution network with a parallel family-planning commodities procurement and distribution system. This could be accomplished within the present federal decentralization program by consolidating all contraceptive commodity purchases at the federal level, while also negotiating what federal and state resources would be dedicated to a national commodities distribution network. Out of this negotiation process viable federal and state contraceptive purchasing and distribution budgets would need to be developed. The political gain here is that even a very modest improvement in commodities availability in public sector

health posts could provide political recognition for both the federal and state political leaders. While the team believes that in Brazil professionals with the appropriate technical skills are available to develop such a plan, initially, USAID may want to consider underwriting some portion of the cost to retain them at the federal and state levels. Pilot programs in Ceará and Bahia may be expedient places to start.

Recommendation No. 2: USAID should also seek to convince national and state governments to take advantage of existing commodities distribution systems now in place. Some states are already purchasing contraceptives, although their distribution systems are weak. BEMFAM has an excellent contraceptives distribution system in place in ten states, which already reaches 1,800 family planning service delivery points and could be utilized for government-provided contraceptive distribution. Also, there exists a viable precedent, whereby BEMFAM already provides family planning and reproductive health services to state and municipal health facilities. Fair and reasonable government payment for reliable contraceptives distribution services with government-provided contraceptives could work in Brazil. Additionally, fair and reasonable government payment for reliable contraceptives distribution services would likely also facilitate new interest within the private sector to provide this service. Currently BEMFAM cannot legally charge for donated commodities, but there is no reason it could not recover costs for purchased commodities.

Recommendation No. 3: The USAID strategy also needs to continue pressing the national government to ease impediments and restrictions that unnecessarily restrict foreign competition in the domestic contraceptives market. The present market ethic of setting high contraceptive prices and limiting domestic production will force the government to seek foreign contraceptives or spend an inordinate amount of money to buy needed contraceptive supplies locally. On the other hand, if increased competition were allowed, the price of contraceptives would likely drop, with a corresponding quality improvement.

Recommendation No. 4: Logistics and procurement systems need to be strengthened at federal, state and municipal levels. The states and municipalities have either weak or non-existent systems for forecasting, purchasing, tracking and ordering contraceptive supplies. Training of administrators to encourage efficient use of mechanisms, the development of logistics and supply procurement systems and employment of sufficient numbers of adequately trained staff will be necessary to have a significant impact on contraceptive choice.

4.1.5 Research and Evaluation

The USAID strategy calls for evaluation activities to measure the achievement of quality and sustainability objectives, including baseline studies. The strategy's implementation plan elaborates on this, specifying that situational analyses will be performed by the Population Council, and that a DHS will be conducted near the end of the strategy period. A detailed evaluation plan for the strategy is to be developed in collaboration with the EVALUATION Project, and CAs will be asked to develop corresponding evaluation plans for their areas of assistance. Plans also call for design and introduction of consistent data collection forms among the various assistance providers. In the areas of research and evaluation, the USAID strategy calls for small-scale research projects to improve program operations and monitor the

QOC provided. Studies to address provider bias against long-term methods such as the IUD and injectables are given particular attention.

Among the most significant accomplishments in the areas of research and evaluation has been the completion of situation analyses of women's reproductive health care in the two target states of Ceará and Bahia. USAID has supported assistance to the women's health programs in the target states in developing their evaluation and information systems. USAID has also made progress in developing a plan for monitoring impacts achieved under its own program (see Chapter 3). Two operations research studies have been carried out under the program, and other research activities are planned. The issue of provider bias in providing IUDs has been addressed through training, rather than research, but other issues relating to QOC have been the subject of studies.

Situation analyses of women's reproductive health care were carried out in Ceará in 1993 and in Bahia in 1994. The Bahia study has experienced some delays, and results were not available at the time of this assessment. The respective state secretariats of health were responsible for coordinating both studies, with technical assistance from the Population Council working under USAID's INOPAL (Operations Research in Family Planning and Maternal-Child Health for Latin America and the Caribbean) project. In each state, the survey was performed with a sampling of municipality health units providing reproductive health services in the state capital and interior. Samples were taken from the same municipalities surveyed in the 1991 DHS in order to link the data sets and strengthen the resulting analyses.

The USAID program has also provided support to the state secretariats in Ceará and Bahia in development of their evaluation plans and information systems, through the EVALUATION Project and Pathfinder respectively. The main objective of this assistance is to develop the state programs' capacity to monitor their activities and to use the resulting data for decision making.

Activities in Ceará have included assistance to the Viva Mulher program in development of a preliminary work plan and in a strategic planning exercise. Assistance and training are currently being provided through a locally contracted evaluation consultant, and a consultant from the Institute for Health and Social Development (ISDS). The EVALUATION Project's plan calls for Viva Mulher staff to take full responsibility for monitoring and evaluation of the program by the end of 1995.

Currently, the Viva Mulher staff are reviewing existing data sources, of which two seem particularly promising: the Sistema de Informacoes Ambulatoriais/Sistema Unico de Saude (SIA/SUS) outpatient reporting system, and the community health worker program's information system. The SIA/SUS is the information system used by the Ministry of Health to reimburse health units for services provided. The forms currently in use for SIA/SUS are quite general, but the consultants to the Viva Mulher program aim to adapt them to provide more specific coding that will supply information needed for program management of the women's reproductive health program. Reports from community health workers' monthly home visits have provided the state with one of its first experiences in using data for decision making. While these reports currently focus on gathering information regarding child health, the Viva Mulher program aims to incorporate questions regarding contraceptive prevalence and other reproductive health information.

In Bahia, SESAB is receiving technical and financial support from Pathfinder to develop a plan for monitoring and evaluating program activities. Substantial progress has been made in adapting the SIA/SUS forms in Bahia, integrating commodity reporting and indicators for service provision in a single report for the first time. The revised SIA/SUS form is being tested as a pilot in six health units, using specially designed software. An additional 124 health units were reporting in 1994 using the revised forms. Pathfinder and SESAB are now working on a plan for expansion of the system. This will include developing SESAB's capacity for data collection and use through workshops at the regional health directorate (DIRES) level. It is expected that 12 to 15 DIRES (of a total of 30) will be using the revised forms by the end of 1997.

Basing information systems in both states on existing reporting systems, instead of creating new systems, increases the likelihood that the new information systems will be sustainable, particularly in the case of the SIA/SUS, which is tied to financial reporting. However, in both states, and to a greater degree in Ceará, the process of converting the municipalities to the new system will be incomplete at the time of USAID phase-out.

The Population Council, through the INOPAL project, has carried out two operations research studies. The first study, addressing postpartum acceptance of family planning methods, was carried out with the HMO Promedica in Bahia in 1992-93. The study found that making contraceptives available to women immediately following childbirth or abortion led to significant increases in acceptance of family planning methods, especially IUDs. The study also showed a reduction in the HMO's costs by decreasing the number of patient follow-up visits to seek family planning services.

Additional research activities are to be supported through Family Health International's Women's Studies Project. The project's objectives are to support social and behavioral science research on the immediate and long-term consequences for women of family planning programs and methods; and to provide information that can be used to improve family planning and reproductive health policies and programs, through increased knowledge of women's needs and perspectives. An in-country advisory committee for Brazil has been formed, and has made recommendations on research priorities. Among priority areas identified is quality of services, including evaluation of the government PAISM system and its impact on women's lives. The committee is currently receiving research proposals.

To date, the DHS and situational analyses in the target states have been accomplished with USAID support, including support to BEMFAM in performing the DHS, and to the Population Council for the situational analyses. A high priority should be given to fulfilling the USAID strategy's provision for supporting a follow-up DHS near the end of the assistance period. Current plans of other donors call for forming a consortium to support a DHS in 1996. This approach would have the advantage of reinforcing involvement of other donors who could continue supporting the DHS after USAID phase-out.

BEMFAM's role in the DHS should be reevaluated. Based on some of its recent personnel changes, it was not clear to the team whether or not BEMFAM retains the capability to carry out all phases of a DHS. It appears that BEMFAM is still capable of effectively managing the complexities of field work and data input. In this case, a consortium or advisory group could be

formed, composed of individuals or institutions, that would have overall responsibility for the DHS while BEMFAM would retain responsibility for field work. This would have the advantage that it would give the DHS wider "ownership" while also building on over fifteen years of BEMFAM survey experience that USAID has helped to build. An alternative would be to seek a private survey group with local field work experience to carry out the sampling with guidance from a consortium/advisory group. Institutionalization of the DHS with Government of Brazil involvement is desirable, but this would depend on the capability of Brazilian institutions such as the Instituto Brasileiro de Geografia e Estatistica (IBGE) whose future capabilities seem uncertain.

Performing follow-up situational analyses represents a relatively low-cost investment (US$110,000 and US$150,000 for the 1993-94 analyses) of great benefit to USAID because of the potential for documenting the impacts of USAID activities. The usefulness of the analyses in evaluating impact will be heightened if they continue to match sample sites with the DHS. This effect would be strengthened further if the situational analyses were scheduled to coincide with a 1996 DHS. However, this may not be possible due to the state governments' interest in scheduling the situational analyses in 1997 to document their end-of-term accomplishments.

Because of USAID's need to continue documentation of the impacts of its programs after the 1997 phase-out, the program should plan for follow-up surveys near the final phase-out date of 2000. Support for both a DHS and repeat situational analyses near the year 2000 close-out should be a high priority for use of the program funds budgeted for evaluation during the post-phase-out period. The program should also set aside funds for a review of overall impact and lessons learned from USAID assistance.

The current leadership of the women's reproductive health programs in both target states seem to have a strong interest in developing good information systems. However, as observed in the USAID strategy, the states have limited capacity and systems for using the resulting data for planning and decision making. Building this capability will be crucial to ensuring that the data obtained from the states' improved information systems are used to inform efforts to improve service quality and sustainability. Hence, assistance to the states should focus, in addition to developing data collection and reporting systems, on developing the programs' capability to analyze data and systems to ensure that the data provided are regularly reviewed and integrated into their decision-making processes. In Bahia, the team had particular concern that despite the successes that have been achieved in developing and testing the monitoring system for output-level data, the area of impact evaluation has not received sufficient attention.

Additional attention should be directed to improving coordination among programs in developing information systems. Efforts to modify the SIA/SUS forms provide a case in point: the women's reproductive health programs in Ceará and Bahia and the AIDSCAP (AIDS Control and Prevention) program in Sao Paulo are all pursuing independent efforts to modify the forms for this important data source. Viva Mulher staff have visited Bahia to study the SESAB's work on the forms, but there are as yet no concrete results. Meanwhile, the AIDSCAP program in Sao Paulo has received assistance from the designer of the SIA/SUS forms to revise the forms, and is testing the modified version in Santos. By coordinating these

efforts, the USAID program could maximize resources and achieve a more uniform product, which could enhance the chances of gaining broader acceptance by health units.

While the topics addressed to date in operations research clearly fit within the Brazil strategy, the operations research agenda could benefit from an even sharper focus on areas posing particular constraints to accomplishment of the strategy. Two areas suggested by the team's observation of knowledge gaps are: 1) research on the commodity purchase and distribution system to identify entry points to orient future interventions and policy dialogue; and 2) studies to test interventions targeted at problem areas indicated by the situational analysis data.

4.2 Improvements in Quality of Care and Their Relation to USAID Support

One of the two desired program outcomes of the USAID/Brazil strategy is to improve the quality of family planning care by expanding the range of methods available, improving the use of family planning methods, and increasing the dissemination of correct information about reproductive health in Northeast Brazil. Due to the relatively short amount of time that has elapsed since the strategy began implementation in late 1992 and the time it takes for CAs to adjust project cycles to the new strategy, very little evidence exists to date that the quality of family planning care has indeed improved in target areas. The DHS, conducted in 1991, and situation analyses conducted in 1993 in Ceará and 1994 in Bahia provide baseline data for measuring changes in QOC. However, they are not expected to be repeated until nearer the end of this assistance period and thus cannot be used for purposes of this assessment. Project-specific data that document improvements in QOC are scant, either because only baseline data have been collected or because no data have been collected to date.

4.2.1 Method Diversification

Due to the overwhelming reliance of Brazilian women on two contraceptive methods, oral contraceptives and sterilization, USAID supports activities in Brazil to promote method diversification. USAID's efforts have been directed primarily toward the supply environment in order to expand the range of methods available, thus giving women a wider choice in the selection of their contraceptive method. It is assumed that as more types of methods become available, women will likely choose methods other than the pill and sterilization. However, USAID/Brazil is also aware that prevalence of these two methods, particularly sterilization, may not change as women become able to choose from a wider range of methods. What is important is that the decision to use a specific method, such as sterilization, is an informed one and not one made for lack of other contraceptive options.

The most appropriate sources of data for measuring method diversification are the situation analyses which describe the supply environment (method availability at the level of the service delivery point [SDP]) and the DHS which characterizes demand for specific methods (method-specific use). Since only baseline situation analysis and DHS data exist, however, the evaluation team has had to rely on BEMFAM and SESAB service data, and the PESMIC survey conducted in Ceará in 1990 and 1994. Utilization of these data have several disadvantages. First, they do not measure the supply environment. Second, BEMFAM and SESAB service data reflect changes in program method mix but not necessarily in the population as a whole. Third, the most recent round of the PESMIC survey was conducted in

1994, only one year into the current USAID/Brazil assistance period. With these limitations in mind, the following preliminary findings can be made:

Northeast Brazil. BEMFAM service data indicate that progress has been made in the Northeast in diversifying the method mix in its statewide programs (see Table 2). From 1992 to 1994, although total CYP output fell four percent, supply of most low-prevalence methods increased while that of high-prevalence methods decreased. For example, diaphragm supply (measured in CYPs) increased 51 percent and supply of IUDs and vaginal spermicides and use of periodic abstinence increased 25 percent or more, as opposed to decreases of seven percent and eight percent in the supply of condoms and oral contraceptives (OCs). In contrast, at BEMFAM-operated clinics in the Northeast (see Table 3) the method mix appears to be changing in favor of greater use of OCs, and, to a lesser extent, the IUD. Supply of OCs increased the most (61 percent), followed by IUDs (7 percent), compared to a small overall decrease (-4 percent) in total contraceptive supply.

TABLE 2

BEMFAM Integrated State Programs
(implemented via state and municipal Secretariats of Health)
Total CYPs Northeast Brazil
1992-1994

	CYPs			% Change in CYPs since 1992	
Method	1992	1993	1994	1993	1994
Orals	117,116	139,948	108,295	12	-8
IUD	15,546	19,928	19,367	28	25
Diaphragm	152	132	230	-13	51
Condom	69,997	67,304	64,789	-4	-7
Vaginal Spermicides	4,355	5,448	5,579	25	28
Periodic Abstinence	331	461	421	39	27
Total	207,497	224,221	198,681	8	-4

TABLE 3

BEMFAM Clinics Total CYPs Northeast Brazil 1992-1994					
	CYPs			% Change in CYPs since 1992	
Method	1992	1993	1994	1993	1994
Orals	1,499	2,384	2,410	59	61
IUD	2,210	2,497	2,374	13	7
Diaphragm	170	131	114	-23	-33
Condom	4,482	5,257	2,.390	17	-47
Vaginal Spermicides	649	708	471	9	-27
Periodic Abstinence	610	523	587	-14	-4
Total	9,620	11,500	8,346	20	-13

Ceará. The PESMIC survey indicates limited change in the method mix in Ceará between 1990 and 1994, although as mentioned, the 1994 survey was conducted only one year into the current USAID assistance period (see Table 4). The principal findings are:

- Tubal ligation and oral contraceptives continue to be the most prominent methods; combined use of these two methods remained approximately the same, accounting for approximately 80 percent of all contraceptive use in both 1990 and 1994.
- Use of tubal ligation increased 22 percent (from 42 percent to 51 percent of all users) between 1990 and 1994 while use of oral contraceptives fell 25 percent (from 40 percent to 30 percent); two election campaigns were held during this period, to which the increase in tubal ligations may, in part, be attributable.
- Use of the IUD increased the most compared to other methods, having quadrupled from .3 percent to 1.2 percent of all users.
- Condom use also increased nearly 50 percent (from 3.2 percent to 4.7 percent), but continues to be low, particularly given its importance in preventing HIV/STD transmission.

TABLE 4

PESMIC State Survey Ceará Current Users of Contraception by Method			
Method	1990	1994	% Change
Tubal Ligation	42.0	49.6	18
Oral Contraceptives	39.3	29.3	-25
Periodic Abstinence/Withdrawal	12.9	12.0	7
Condom	3.0	4.6	53
IUD	.3	1.2	300
Injectables	2.2	1.5	-32
Vasectomy	.3	.3	0
Others		1.5	
Total	100	100	

BEMFAM service data indicate that changes in the method mix (measured in CYP) in the Ceará statewide integrated program are similar to those in all BEMFAM integrated programs in Northeast Brazil. With the exception of the condom, supply of low-prevalence methods (IUD, diaphragm and vaginal spermicides) increased, while overall supply of all methods (total CYP) decreased, including supply of oral contraceptives.

Bahia. According to BEMFAM service data for the statewide integrated program, supply of all methods (except use of periodic abstinence) increased from 1992 to 1994. Of all methods, IUD supply increased the most (61 percent), double the overall increase in CYP (30 percent). Increases in supply of other under-utilized methods, such as the diaphragm and spermicides, increased at approximately the same rate as that of oral contraceptives.

SESAB service data confirm the trend in method diversification at public sector SDPs in Bahia. From 1993 to 1994, supply of the IUD and vaginal spermicides increased 33 percent and 45 percent respectively, while supply of all other methods decreased, including tubal ligation and oral contraceptives.

4.2.2 Improved Method Use and Wider Availability of Reproductive Health (RH) Information

Baseline DHS data exist regarding the effectiveness of method use and availability of RH information. Data from the situation analyses also provide information on the latter area. Since second rounds of both surveys are scheduled later in the current assistance period, it is too early to evaluate improvements in method use or whether reproduction health information is more widely available.

4.2.3 USAID Contribution to Improved Quality of Care

Method Diversification. Since implementation of the current USAID population assistance strategy, BEMFAM and SESAB service data indicate that small improvements may have occurred in program method mix in the Northeast, particularly with regard to increased use of the IUD. Findings from specific projects also indicate availability of a wider range of methods and changes in the method mix:

- In Bahia, of 14 SDPs where SESAB has trained providers with assistance from JHPIEGO, the number of IUD insertions increased from 1993 to 1994 in all institutions except one. Half of them doubled or nearly doubled the number of IUD insertions from one year to the next.

- In Ceará, of 31 SDPs where JHPIEGO sponsored training of providers, 42 percent offered diaphragm fittings following training as opposed to 10 percent prior to training; IUD insertions were offered by 74 percent following training compared to 48 percent before training.

- In Rio Grande do Norte, Paraiba and Alagoas, IUD use (measured in CYPs) in the statewide integrated program increased 6 percent from 1992 to 1994, compared to a decrease in supply of all other types of contraceptives. Pathfinder has been supporting BEMFAM in these states with the specific objective of expanding IUD use.

At the population level, there is cause for concern at the decrease in oral contraceptive use and the large increase in tubal ligation identified in Ceará (and quite likely in Bahia) in 1994, which mask small gains made in the use of other low-prevalence methods, such as the condom and IUD.

Method Use and Availability of RH Information. Since only baseline data exist to date, the team is unable to document improvements in method use and availability of RH information as a result of USAID assistance. If improvements have occurred, they are likely to be small at the program level and negligible at the population level since USAID IEC efforts (primarily via the Population Communication Services (PCS) project {the Population Communication Services project}) have focused on TOT in IPC/C at selected public sector training centers. Improvements in these areas are anticipated in Ceará and Bahia once a complete communications strategy is implemented with PCS assistance, including use of the mass media and print materials for information dissemination and counseling.

4.3 Suggested Changes in USAID Assistance for Improving Quality of Care

USAID/Brazil and its CAs are well aware of the QOC issues affecting reproductive health service delivery in Northeast Brazil. However, with few exceptions (BEMFAM is one of them), Brazilian reproductive health managers and providers have not been exposed to the concept of QOC as it has developed in US academic and international family planning circles. While many Brazilian public health leaders emphasize the importance of quality reproductive health

care, they lack operational definitions. In order to accelerate improvements in QOC, it is important that USAID:

- Disseminate Portuguese-language information on QOC (such as the Judith Bruce QOC conceptual framework, the FPMD Pocket Guide to Service Improvement, the EVALUATION Project QOC indicators, among others) to reproductive health managers.

- Create awareness about the problem of reproductive health care quality by greater and more focused dissemination of the results of the situation analyses (and DHS, with a focus on QOC), in easily understandable form.

- Promote discussion of the results of the situation analyses and DHS such that reproductive health managers can target specific interventions and set goals to improve QOC.

During the remainder of the current assistance period, USAID should continue efforts to improve QOC by promoting diversification of the method mix, improved method use and wider availability of RH information. To date, USAID CAs have emphasized the role of the IUD in diversifying the method mix, most likely because of the training required to be able to provide it and strong medical barriers that need to be overcome to promote it. While the IUD is an important underutilized method, CA activities should seek to promote all methods. Condoms and vasectomy, for example, are two important methods that have received little attention during this assistance period.

Since situation analysis baseline quality indicators highlight marked differences in quality between the metropolitan area and the interior, USAID efforts to improve quality during the remainder of the assistance period should focus particularly on the interior.

5 SUSTAINABILITY

5.1 Sustainability of Program Sectors: Current and Anticipated Levels

Sustainability is a priority objective for USAID assistance in Brazil. This objective focuses on strengthening of service delivery systems in the public, private, and NGO sectors and not necessarily on the sustainability of specific institutions. Assistance to institutions will be determined by their contribution to the overall sustainability of a sector. The three sectors are discussed separately below for purposes of discussion, but the team recognizes they are not free standing but interrelated. Sustainability of service delivery systems is defined as:

- Full assumption of responsibility for the costs and implementation of family planning services by state and local health facilities in project sites
- Replacement of USAID-donated contraceptives with a reliable alternative supply system
- Financial viability of NGOs supported through the strategy to continue without USAID funding and commodities

5.2 Public Sector

Under the USAID Brazil strategy, public-sector implementation of PAISM is being supported in two states: Bahia and Ceará. Several USAID CAs support this effort by providing contraceptives, training, technical support on IEC, and technical assistance for strategic and operational planning. Evaluation and monitoring assistance have also been made available.

5.2.1 Ceará

Through its Viva Mulher Program, Ceará made a somewhat earlier start in the active implementation of PAISM at the state level. Viva Mulher builds on the state's earlier and very successful effort to increase child survival (Viva Crianca), which had strong support from UNICEF. Viva Mulher receives substantial financial support from UNFPA, which has supplied contraceptives directly and via the Ministry of Health in Brasilia, along with direct support for training, IEC materials, institutional support and equipment in the state. UNFPA recently supplied all municipalities in Ceará with a reproductive health post equipment kit, including an examining table and various instruments.

Availability of reproductive health services in the state is varied. According to a situation analysis research project carried out during 1993 in 23 municipalities, there is considerable variability in the availability of reproductive health services among the 268 service provision points included in the study. The study found a broader range of services was available in metropolitan Fortaleza than in municipalities of the interior. Cancer screening, gynecological examinations, and prenatal care were available in more than two-thirds of the facilities visited in Fortaleza. In the interior, prenatal care was the only intervention available at about two-thirds of the facilities.

The discrepancy in family planning services between Metro Fortaleza and the interior was smaller in that family planning was lacking in about two-thirds of the facilities in both areas. The difficulty appeared to be lack of municipal-level political commitment to implementing service delivery rather than lack of demand. About 75 percent of family planning method users interviewed in the study procured their supplies at pharmacies rather than health posts because of the unavailability of supplies at the posts. Also, there was very little information or promotion of family planning at health posts.

By 1997, Viva Mulher is intended to provide a full range of reproductive health services through health facilities in the state's 182 municipalities, including safe pregnancy and delivery, prevention and management of sexually transmitted diseases, detection and treatment of cervical, uterine and breast cancer, and a full range of contraceptive methods.
In discussing the sustainability of reproductive health services in Ceará, distinction should be made between the previous and current state government's commitment to the program and the role of municipal commitment in assuring service implementation and sustainability. A good indicator of future sustainability is the stronger commitment on the part of the current state government to implementing Viva Mulher when compared to the previous administration. Though Viva Mulher was started during the previous administration, it did not receive full support of senior Secretariat of Health staff. In contrast, the new State Health Secretary is supportive of the program and went out of his way to show his support during the assessment team's visit. The current stronger state-level commitment to the program will certainly translate into more effective USAID technical support for key state-level functions (such as training, IEC and contraceptive logistics) and their sustainability. However, with few exceptions, the state is not responsible for service delivery. Since most municipalities in Ceará now operate decentralized health systems, political commitment at the municipal level is key to assuring that services are indeed implemented and service delivery sustained. In Ceará, there is a clear need to broaden the base of municipal political support for reproductive health, an effort that is complicated by the tradition of using health as a pawn in the electoral process—a factor contributing to the widespread practice of trading surgical sterilization for votes.

The completion of the strategic plan, once key stakeholders are brought into the process, will help with "big picture" issues such as donor coordination, broadening of political support, and financial sustainability. The Viva Mulher program coordinator indicated that it might become more of a reference point for program management in the future.

5.2.2 Bahia

In Bahia, the strategic planning process appears to have been more influential in mobilizing institutional commitment to reproductive health at the state level. Bahia's effort to implement its reproductive health strategy is still at an early stage, but its launch has benefited from the very strong support of both the previous and new state administrations and from the involvement of a larger number of high-level officials in the strategic planning process. The Bahia plan states specific objectives for state and municipal funding of reproductive activities in the state, and calls for increasing the number of women of reproductive age receiving state provided family planning services from 15 to 25 percent by the year 2000.

Discussions with staff in the State Health Secretariat suggested that while there is political and institutional support for the reproductive health strategy, the funding and institutional capacity for implementing it still need to be strengthened. Another consideration about the Bahia strategy is that while it bears the label "reproductive health," much of the content is focused on family planning. While this may be appropriate given the limited amount of family planning available through the public sector in Bahia, it was also clear that other state-level health managers' interests in the strategy were in the donor financing that it could attract. This leaves a question about how sustainable the commitment in Bahia for public sector support would be in the event that outside financing were not forthcoming, or if key staff were to leave the program.

Results of the situation analysis in Bahia were not yet available at the time of the team's visit. A representative of the research team who was present at the CAs meeting in Fortaleza reported that the Bahia findings were similar to those in Ceará. Bahia, with over 400 municipalities, faces a substantially greater challenge in implementing PAISM in the interior of the state. BEMFAM currently supplies contraceptives to 95 municipalities in the state, and BEMFAM's state director reported that there was very little family planning activity in municipal health posts other than those in the BEMFAM network. While Bahia is not as far advanced as Ceará in decentralizing health services, political commitment at the municipal level in Bahia is also key to assuring service implementation and sustained delivery.

5.2.3 Sustainability Considerations

USAID began to target assistance to the public sector in 1993, the beginning of this assistance period. Given the time required to start activities, the slower nature of public sector implementation compared to NGOs, and the importance of building political commitment at the state and municipal level, the current strategy underestimates the time required to fully develop sustainable service delivery systems in the states of Bahia and Ceará. Service delivery systems are not expected to be entirely sustainable by 1997 and technical assistance will be required for specific functions through 1999. In order to increase the chances of sustainability by 1999, the following areas merit special attention:

Financing. Because of municipalization and problems with implementation of SUS, state-level public-sector financing of reproductive health activities is quite precarious. To be sustainable in the public-sector system, key activities (training, IEC, commodities) will need to be regular budgetary line items.

Integration. Integration of family planning and other reproductive health activities into the mainstream of primary care and institutionalization of key functions (e.g. training, IEC) within the organizational structure of state and municipal health secretariats will most likely increase the chances of sustained support once outside assistance is withdrawn. To the extent that these activities are perceived as "add-ons" to support as long as a donor is interested in them, sustainability is in doubt. Close coordination with other elements of the primary health system is thus needed. (In Bahia important steps are being taken in this direction to assure institutionalization of specific functions. A supervision project will be implemented by the SESAB department responsible for supervision and the Health Information Center will implement the project that will decentralize the SISMAC information system).

Training. There is continued need for training at all levels of the system (from management capacity in the state secretariats to in-service training for physicians, nurses, and health agents, as well as preservice training for medical and nursing students). A reassessment of training needs given earlier investments and changing needs would be helpful. Special efforts are needed to address the substantial level of physician bias and lack of interest in family planning.

Supplies. Lack of contraceptives and other supplies, and limited capacity to get supplies that are available to the PSD are serious constraints on the sustainability of state-level provision after the current system is phased out. National- and state-level systems for the procurement of essential medicines are supplying other items. Contraceptives are now included in these agencies' supply lists, but the actual procurement and distribution of methods is still a trickle, except for those being donated by USAID and UNFPA.

Commitment. Political support and commitment to family planning has increased at top levels of both the federal and state governments. Understanding and interest in the reproductive health agenda is generally weak at the municipal level, however. Given the important role that municipalities are expected to play in the delivery of primary health care, much effort is needed to build stronger commitment to this agenda among local officials and their constituents.

5.3 Private Sector

The private health care sector in Brazil is responsible for providing a significant proportion of family planning services in the country. Within the private sector, pharmacies are the most significant provider. To a lesser extent, family planning services are delivered through for-profit health care providers, including prepaid group practices and medical cooperatives. The 1992 strategy team felt the private sector, which had been historically ignored by USAID, offered the potential to leverage USAID funds and help achieve service delivery and sustainability objectives proposed by USAID. The ensuing strategy, therefore, identified a three-pronged approach to activities in this area:

- A joint venture partnership with a private sector provider, such as a prepaid group practice or medical cooperative, to include family planning in the services they offered and reimbursed

- The development of a phase-out plan for commodities which would establish an entity to perform a broker role between the commercial manufacturers and distributors on the one hand and the NGO and state government sectors who would purchase these supplies on the other

- Collaboration with the pharmaceutical industry to make underutilized and/or expensive methods, such as injectables, IUDs and condoms, commercially available

5.3.1 UNIMED

For the first part of the three-pronged approach, UNIMED, a large medical cooperative in Brazil, was chosen as a potential partner for a joint venture partnership with a private sector health care provider. The UNIMED venture is reviewed here both in terms of financial sustainability but most importantly in terms of strategic objectives and how it ties into USAID's overall strategy. UNIMED was identified as a private sector provider with interest in integrating family planning services into its existing health reimbursement system. The primary objective behind the relationship was to create a model within the UNIMED system that could be later replicated at no or little additional cost to USAID. A second objective was to use profits from this venture to fund or cross-subsidize activities important to attaining USAID's objectives. Overall, the relationship was viewed as an important step towards improving the contraceptive method mix, improving access to family planning, expanding the provision of family planing services through the private sector, and sustainability objectives. Two initiatives have been funded:

Aracaju. A joint venture was formed between The PROFIT Project and UNIMED in Aracaju. After initial investments and disbursements on the part of PROFIT, UNIMED management decided not to honor its contract to proceed with the venture. A solution to this problem was settled out of court in favor of PROFIT. USAID funds were recovered in full.

Maceio. A joint venture was formed between UNISERV (UNIMED in Maceio) and the SUMMA Foundation (PROFIT). An initial cash outlay of US$2.2 million financed the purchase of a small hospital in December 1993. UNISERV held 51 percent of the stock and contributed US$1.122 million of the investment. SUMMA was the minority stockholder with 49 percent and contributed US$1.078 million. The hospital, Centro Medico Sao Sebastiao (CSSS) was kept open during the remodeling period in 1994 and is now a modern general medical facility providing emergency and inpatient care. A diagnostic center located in an adjacent connecting building was subsequently added and an MCH clinic is to be located in a nearby leased building. The CSSS and diagnostic center are fully operational and are expected to break even in late 1995. The MCH clinic is expected to open by May 1995 and become sustainable by October 1996. Twenty-three physicians were trained in family planning; they have inserted sixty IUDs in their private practices while awaiting the opening of the MCH clinic.

The achievement of non-financial objectives will be more difficult. The UNIMED venture encountered a series of unexpected obstacles:

UNIMED commitment. UNIMED senior leadership is displaying less than expected interest in family planning services. For example, the MCH clinic, which was expected to be housed within the hospital, is located in a rented facility several blocks away and its completion has been a low priority.

Cancellation of SUS clients. The government canceled its agreement with the CSSS to serve patients covered by the government program Sistema Unico de Saude (SUS) when UNIMED entered into a joint venture with PROFIT. Collaboration with an organization that was funded by an international donor became politically sensitive. (As noted in Chapter 2, there is a bill, passed by the Chamber of Deputies and currently in the Senate, which prohibits funding of family planning activities by international donors unless authorized by SUS.)

Replicability. The objective of replicating this model within the UNIMED network at no or little capital cost to USAID will not be possible. Even if the UNIMED/Maceio venture had been highly successful, UNIMED is an independent physician cooperative with no centralized decision-making authority with the power to implement policy changes at other cooperatives.

Client Profile. The UNIMED client is middle class, better educated, and more aware of family planning than the average resident of Maceio. For example, the contraceptive prevalence rate (CPR) of the UNIMED population is 75 percent as compared to 54 percent for the general Maceio population. The number of children desired is 2.1 as compared to 2.7, and the number of live births is 1.1 as compared to 4.5 in the general population. Method mix, while less skewed, still favors sterilization and OCs.

Improving Access to Family Planning Services. UNIMED physicians already offer family planning services in their private practice. Once the MCH clinic is open these physicians will transfer their clients to the clinic. Since these are not "new" family planning clients, PROFIT decided to shift strategy and focus not only on the UNIMED population but also on the lower income population of Maceio. A marketing plan is being developed to reach this population. Nevertheless, several obstacles must be overcome to meet this new objective:

- Unwillingness of UNIMED physicians to decrease the price of their services for low-income persons
- Physician preconceptions that poorly educated women are incapable of making an informed choice about family planning methods
- Physician lack of training in family planning in general and counseling in particular
- Fear that receiving low-income clients in the clinics would keep away higher-income and UNIMED clients
- No interest on the part of UNIMED management in serving a lower-income population

In order to overcome these obstacles and meet family planning objectives, several activities are being conducted with the objective of sparking interest in physicians. They include:

- Training in family planning methods and counseling techniques
- Providing an opportunity to conduct clinical follow-up studies
- Using the expansion of services to a lower-income population as a way of enhancing UNIMED's public image
- Assisting with promotional activities

It is unclear whether these activities will be sufficient to surmount the obstacles.

After a detailed review of the current structure of the UNIMED venture, meetings with key PROFIT and UNIMED staff, and careful consideration of achievable objectives, the assessment team does not feel this venture is contributing to USAID's overall objective of using a private sector network to improve access to or expansion of family planning services. The team does not envision accessing many new family planning users through the UNIMED Maceio system nor does it feel there is a commitment on the part of UNIMED Maceio to reach out to the lower socioeconomic population in the city. There is also a concern with the low level

of commitment to family planning. There is potential for impacting quality of family planning services by improving the method mix offered by UNIMED doctors to their clients through training in family planning; however, this objective could be attained in a more cost-effective manner. The team, therefore, recommends an exit from the joint venture.

PROFIT should seek guidance from counsel to determine the most appropriate and productive manner in which to negotiate the sale of its 49 percent share to UNIMED. The team recognizes that this will not be an easy task. There is no provision within the by-laws allowing for a smooth transition of shares before a four-year period. Market value of the land and building will need to be negotiated and accurate balance sheets prepared. On the positive side, the real estate value has increased three-fold and the CSSS and diagnostic center, which only began full operations in January of 1995, are close to break-even point. Negotiations should strive for recovery of the original investment adjusted for inflation and opportunity cost. USAID should consider using this capital, as well as money recovered from UNIMED/Aracaju, to strengthen the CEPEÓ, if necessary, to conduct management and training activities in Bahia and Ceará, or for other activities consistent with USAID's strategic objectives.

It should be noted that during a briefing with PROFIT, the team learned of new activities being pursued with the Fundacao Oderbrecht. One is a financial venture to open a polyclinic in the south of Bahia; a second is the development of hospital/clinic administration systems software which would in turn be used to sell systems administration consulting services to the private sector. Based on the priority needs in Brazil, the short phase-out timeline and limited resources available, the team does not feel it is appropriate to pursue these activities.

5.3.2 CEPEÓ

The CEPEÓ (a commodities procurement organization), is a commercial venture set up to establish commercially sustainable operations oriented towards the procurement, promotion, and distribution of high quality and reasonably priced contraceptive products to the private, public and NGO sectors. The focus on long term sustainability is to assure continuity of its socially oriented goals.

CEPEÓ is financed with funds provided by PROFIT and social marketing support from the Social Marketing for Change project (SOMARC). Specifically, its immediate purpose is to provide a continuing, low-cost source of contraceptive commodities for previous Pathfinder clients. Its longer range purpose is to generate revenues to underwrite reduced price contraceptives for NGO and public sector customers. It will do so by selling a full range of contraceptive and reproductive health related commodities to private individuals and retailers. CEPEÓ will use commercial loans, not USAID funding, to purchase commodities on both the international and domestic markets. The first CEPEÓ contraceptive registered for sale in Brazil is the Copper T-380, from Finishing Enterprises. It sells under a registered brand name and as a bulk product for public sector and NGO distribution. The first shipment of 20,000 Copper T-380's arrived in Brazil in late March 1995. CEPEÓ will need to sell 88,000 IUDs to break even; the marketing plan relies heavily on transfer Pathfinder clients who currently purchase approximately 55,000 IUDs. In addition, CEPEÓ is negotiating a joint venture with London Rubber to import three brands of condoms. CEPEÓ anticipates achieving self sustainability before USAID support terminates in 1997.

5.4 NGO Sector

NGOs have been leaders in introducing family planning in Brazil. Although their role in direct delivery of family planning services has been limited compared to the public and commercial sectors, they have made contributions in training, IE&C, supervision and contraceptive supply.

5.4.1 The Brazil Society for Family Welfare

BEMFAM, an affiliate of the International Planned Parenthood Federation (IPPF), was established in 1965 and is the largest not-for-profit group active in reproductive health care. Much of BEMFAM's work is through convenios or contracts with government and business; in 1994, BEMFAM had 1,200 signed agreements (84 percent with governments, 7.2 percent with industry and 8.8 percent with community organizations). Under these convenios, BEMFAM commonly supplies contraceptive methods, information and education, training for medical staff, and evaluation instruments. BEMFAM also conducts research projects, including demographic and health surveys; and provides clinical services including prenatal care, cervical cancer screening, family planning, pediatrics and general gynecological checkups through eleven service clinics and three laboratories. In the Northeast, BEMFAM has contracts with state and municipal secretariats of health to support family planning services provided by public sector personnel at municipal health posts. It is the major source of commodities for the public sector in this region.

BEMFAM has historically depended on USAID assistance, channeled mainly through IPPF and Pathfinder and IPPF/WHR. Institutional capacity to recover costs has been very limited until very recently. BEMFAM now has a six-pronged strategy for increasing local income and improving sustainability which includes:

- Introducing or increasing fees in all 11 clinics
- Renegotiating payments received for "convenios" (agreements)
- Increasing agreements and net revenue from three labs
- Launching a commercial condom venture
- Commercial sales of IUDs
- Decreasing headquarters costs

BEMFAM has succeeded at increasing revenues from its laboratories and program "convenios" and is currently recovering 42 percent of all costs (excluding contraceptives). BEMFAM projects that it will be 52 percent sustainable by the time USAID assistance phases out.

This assessment of BEMFAM future sustainability builds on a recently completed evaluation of the IPPF/WHR Transition Project which looked specifically at BEMFAM progress in this area. Although there are various important aspects of sustainability, such as technical and institutional sustainability, this report will focus on the bottom-line financial aspect. The team recognizes BEMFAM's diligent work to increase revenues and launch a new condom commercial venture. Nevertheless, the team was concerned with the pace of progress in BEMFAM's sustainability plans and with a perceived lack of commitment by senior staff to a

well thought out phase-out plan. For example, the sustainability plan, which was developed by BEMFAM and IPPF in 1993-94, was out of date and not in use. Senior staff explained that there were no immediate plans to update it. Sales under the new condom commercial venture were scheduled to start in April, yet no sales agreements or representation contracts had been signed. Contact with possible buyers, to date, had been informal. There was no clear strategy for addressing the negative cash flow generated by the clinics. Considerable reliance seemed to be placed on a plan to increase lab revenues. While the plan seemed solid and plausible, there was no operational plan for implementation.

In addition, The projected 52 percent cost recovery by 1997 is questionable because (1) the cost of donated commodities has not been imputed into the sustainability equation; (2) BEMFAM is relying on generating considerable revenue from contraceptive sales, yet the institution lacks experience in the commercial sector; (3) national-level protectionist policies are expected to impair short-term entry into the condom market; and (4) the states, in the medium term, are likely to develop their own purchasing arrangements for commodities, thereby eliminating the revenue generation niche that BEMFAM has historically relied upon. Aggravating the situation are mixed messages from different donors regarding the urgency of taking concrete steps to insure sustainability.

BEMFAM will need to launch a major, intensive operation, spearheaded by senior management, to address both the difficulties of reaching the projected 52 percent cost recovery by 1997 and the 48 percent shortfall. If major steps are not taken without delay, the team does not believe the institution will be any more sustainable once USAID funding and commodities are terminated in 1997 than it would be if that support were terminated immediately. Following are key areas BEMFAM should consider as it plans its phase-out strategy:

Laboratories. BEMFAM has developed a promising plan to increase lab revenues by doubling the number of pap smears performed. The labs are currently working at 50 percent capacity; an increase in tests could be accomplished with current staffing structure in place. The lab directors' meeting scheduled to take place should develop a marketing strategy including identification of "buyers", marketing materials, sales presentations, and prices/structure. Targets and benchmarks should be clearly set, and follow-up periodic meetings should be conducted with the directors to discuss progress, constraints, modifications to the strategy, and expected results.

Clinics. Clinics are BEMFAM's strongest assets, yet they are grossly unprofitable. They currently recover 22 percent of costs (excluding commodities). Four of the eleven clinics do not charge for services. A clinic directors' meeting should take place immediately to review:

- Management training needs (costing, pricing, marketing of services) and how to address them
- Lessons learned in pricing of services including a sliding scale approach
- Marketing of services to the public

Those clinics that are not expected to contribute to institutional sustainability and are not serving large numbers of clients should be closed.

Convenios (government contracts). The key ingredient to these agreements is the provision of contraceptives. With the implementation of the SUS and the municipalization process, state and municipal secretariats will have the ability and resources to procure and purchase their own contraceptives. Many of the convenios with BEMFAM, therefore, will no longer be seen as essential by the public sector. BEMFAM will need to position itself to take advantage of this new structure by selling its expertise and services. For example, BEMFAM should consider selling:

- Contraceptives to the public sector at prices they can afford while still producing a profit for the institution
- Expertise as a commodities distributor
- Medical staff training, IE&C materials and evaluation expertise

If market positioning is not executed quickly, revenues from this program area will decrease sharply in the medium to long term.

Condom venture. BEMFAM has received technical and financial support from SOMARC to plan a commercial condom marketing operation. To assist the effort, USAID is giving BEMFAM 10 million condoms, 3.5M of which are expected to arrive in Brazil in May. Once they arrive, BEMFAM will face the challenge of the government's indirect protectionist policies against imported commodities. National Institute of Measurement, Standards and Institutional Quality (INMETRO) has been slowing down the process of clearing commodities into the country through their testing requirements and bureaucratic procedures. The BEMFAM marketing director should immediately negotiate and sign agreements with distributors. These activities should not wait for the arrival of the commodities.

In addition to assisting with the four areas outlined above, USAID assistance could also be offered in the following areas:

Image building. BEMFAM is still very concerned with its historical image in Brazil and preoccupied with defending its mission and objectives. BEMFAM must focus its time and energies on marketing the good it has done and the populations it has served. This will prove essential as advocacy activities with Congressional staff members increases. PCS could assist with the development of this new image and its marketing.

Perception of future funding. Clear messages must be given to BEMFAM senior management from all donors. Phase-out planning founded on conflicting messages will hinder the process.

Phase-out planning. A clear and realistic phase-out plan being prepared for IPPF must include all the hard decisions such as clinic closures. Additional attention should be given to outsourcing as a way of decreasing indirect costs.

5.4.2 Pathfinder-supported Institutions and Activities

Pathfinder has been providing support to family planning programs in Brazil since the late 1970's. The fact that SESAB is now implementing reproductive health services is largely due to Pathfinder's on-going technical and financial support. Initially Pathfinder operated as a

grants management agency, but in recent years it has strengthened its technical capacity in order to offer technical assistance to local institutions, particularly in the areas of clinical service delivery, commodities logistics and information systems. Pathfinder is gradually transferring technology to local institutions in these areas. For example, Pathfinder has been the main actor in designing and managing the SESAB MIS and contraceptive logistics system and is transferring these functions to SESAB this year.

As a result of Pathfinder's increased technical capacity, it has not only assumed responsibility for selected activities, but also the role of a project implementing agency in some cases. When this has happened it has been due to the inability of a local institution to carry out a project during its implementation. Following the bankruptcy of CPAIMC (an NGO) several years ago, Pathfinder immediately assumed management of its commodities distribution project in order to assure uninterrupted contraceptive supply to hundreds of institutions in Brazil. FEBRASGO, the national OB/GYN federation, was the implementing agency for a postpartum/post-abortion (PP/PA) IUD project. When FEBRASGO failed to successfully execute project activities, project management was transferred to Pathfinder at the time of renewal.

The sustainability of Pathfinder's activities and projects is questionable. Pathfinder is keenly aware of the implementing role it has played in development of the SESAB MIS and contraceptive logistics information systems and is now transferring these functions to SESAB staff. However, the systems are not expected to be sustainable by 1997 and will require technical assistance thereafter. Pathfinder's commodities procurement, distribution and management activities are being transferred to the CEPEÓ this year and are expected to be sustainable since purchased contraceptives will be procured and sold at prices comparable to those offered by Pathfinder (see discussion of sustainability of the CEPEÓ in Section 5.3.2).

One program functional area in which Pathfinder has had a significant implementing role without strong indication of continued sustainability is IEC. Pathfinder has created a number of IEC materials, particularly for PP/PA contraception, utilizing individuals (as opposed to institutions) for their development. In the absence of continued USAID support, this approach to development of IEC materials is not sustainable since it has not contributed to increasing institutional capacity in IEC. In the future Pathfinder does not plan to use this approach, although the Pathfinder strategy for continued work in this area is not clear. Consideration should be given to supporting activities and institutions, such as the SESAB IEC department, that will be able to continue to produce reproductive health IEC materials once Pathfinder support is no longer available.

ABEPF. The Associacao Brasileira de Entidades de Planejamento Familiar (ABEPF) is an association of institutions, primarily NGOs, that provides family planning services. It was established in the early 1980's by health personnel from throughout Brazil trained in large USAID-funded family planning programs. The number of active affiliate institutions is approximately 25, compared to more than 100 in the past. It has four employees. Since its founding, ABEPF has heavily relied on USAID funding via CAs. At present the only USAID-funded activity at ABEPF is preparation and distribution of *Planejamento Agora*, a monthly newspaper that includes copies of articles in the press about family planning and related topics, accompanied by editorials. *Planejamento Agora* is distributed to 10,000 individuals, including all senators, federal deputies and mayors. Planejamento Agora has been produced

for more than ten years, however its effectiveness in raising awareness and promoting policy dialogue is likely very limited.

Pathfinder provides ABEPF support to produce *Planejamento Agora*, which covers 30 percent of ABEPF's personnel costs and 100 percent of the newspaper's production. Pathfinder support for this activity will terminate in June 1995 at which time ABEPF plans to cease publication of *Planejamento Agora* for lack of funding. In addition to membership dues, ABEPF raises revenue from the sale of IEC materials and training manuals developed with USAID funding in the mid-to-late 1980s. Stocks of these materials are very low and soon will no longer generate income for the institution. With termination of Pathfinder support and progressively less income from the sale of IEC and training supplies, ABEPF's future is tenuous at best.

Termination of Pathfinder support for *Planejamento Agora* does not invalidate the need for a vehicle to raise awareness and promote policy dialogue about reproductive health, including family planning. USAID has begun to seek other institutions that can play this role more effectively, perhaps using other communication strategies.

Provision of Commodities. Pathfinder currently provides contraceptive commodities to numerous institutions in Brazil, many of which are NGOs, and is transferring this function to the CEPEÓ this year. The sustainability of family planning services provided by NGOs currently relying on Pathfinder for commodities will ultimately rest on their ability to purchase commodities from the CEPEÓ or from other sources at prevailing market prices. The first product to be made available by the CEPEÓ is the IUD, which will be sold at the same price as the contribution currently requested by Pathfinder for IUDs. Because the price will remain the same, the switch from Pathfinder to CEPEÓ as a source for IUDs will be very easy for the NGOs. CEPEÓ intends to gradually include a full range of contraceptives in its product line; however, the specific products to be offered and their prices have yet to be determined. Affordable prices are a key factor in assuring a sustainable contraceptive supply by 1997 to the NGOs that currently rely on Pathfinder for commodities.

Those most likely to be affected by the transfer of commodity distribution to the CEPEÓ are the small NGOs that have relied on Pathfinder-provided contraceptives for years. These institutions will likely continue provision of family planning services in the absence of Pathfinder-provided commodities. However, their procurement patterns may change, such as purchasing smaller quantities of higher-price methods or purchasing only when funds are available, thereby increasing the possibility of stock-outs and negatively affecting QOC in terms of method availability.

Provision of PP/PA FP Services in Public Maternity Hospitals. Since 1990 Pathfinder has supported training of physicians and nurses from public maternity hospitals in north and northeast Brazil in provision of PP/PA IUD services. Three training centers have been established and 28 service sites currently provide services, 20 of which are located in Bahia.

In terms of sustainability, the program has been very successful in the State of Bahia. In the past Pathfinder has acted as the implementing agency for project activities carried out within SESAB by coordinating training activities, distributing IEC materials and collecting data on services provided. These functions are now being turned over to SESAB where PP/PA IUD

services are viewed by SESAB as a routine service to be provided within the reproductive health program. Given continued political commitment to reproductive health in Bahia, SESAB PP/PA IUD services should be entirely sustainable when USAID support is withdrawn in 1997. The only outstanding issue in regard to SESAB service sustainability is the continued availability of IUDs as Pathfinder withdraws its commodity contributions.

The introduction of PP/PA services, and consequently the potential for their sustainability, has been less successful in states outside of Bahia. Numerous physicians have been trained as providers; however, services have not been institutionalized as they have in Bahia. In the future Pathfinder plans to provide TOT training to health personnel from states outside of Bahia (particularly Alagoas, Paraiba and Rio Grande do Norte) who have already participated in provider training. The sustainability of PP/PA services depends on the wider issue of sustainability of family planning services in general. Attempts to introduce/expand and sustain PP/PA contraceptive services in states where political will or commitment to reproductive health is weak are less likely to succeed. In its efforts to expand PP/PA services beyond Bahia, Pathfinder should focus its activities on states where there is demonstrated government commitment to reproductive health, such as Ceará. Recognizing that earlier training for providers from Ceará has taken place with limited success, Pathfinder may wish to reassess its strategy, particularly in view of the change in state administration and stronger anticipated commitment to reproductive health.

6 SUGGESTED AREAS OF USAID COOPERATION WITH THE FEDERAL GOVERNMENT IF CURRENT RESTRICTIONS ARE LIFTED

6.1 Limitations

As noted in the introduction, direct USAID assistance to the government of Brazil has been prohibited because of outstanding debt and nuclear non-proliferation issues. In the event that these issues are resolved, USAID could resume direct support for family planning and reproductive health activities in Brazil. If this were to happen, it would come at a point at which only two years of funding remain under the USAID population phase-out strategy. In view of this, our recommendations focus on (1) initiatives that could build on current work with the private sector to address key obstacles to public-sector implementation of PAISM, (2) issues that could be dealt with through policy dialogue, and (3) areas in which current family planning efforts could be consolidated with or better linked to other reproductive health initiatives which USAID plans to continue supporting beyond 1997. The following are suggested areas for action:

6.1.1 Enhancing Public-Sector Capacity to Procure and Distribute Contraceptives

A key obstacle to the sustainability of public-sector provision of family planning/reproductive health services is its very limited capacity to supply contraceptives and other supplies to municipal health posts. BEMFAM has been the major supplier of contraceptives to municipalities with which it has *convenios*. UNFPA and Pathfinder also provide methods, with the latter's responsibilities being transferred to the private-sector CEPEÓ organization. Under the USAID strategy, subsidies for commodities will be phased out by 1997. Most municipalities do not have the capacity to purchase commodities, nor is the current system by which municipalities reimburse BEMFAM likely to be able to cover the full cost of commodities.

Brazil's central medical stores system now has a mandate to procure and supply methods to the states and municipalities, but has barely begun to do so. In addition to problems with procurement, there are also serious problems with the logistics system, as noted in Section 4.1.4. These are functions that involve all levels of government (federal, state, and municipal) and financial flows between them. Many of these issues are addressed in recent reports by UNFPA and WHO/HRP, and selective support by CAs to the public sector to address key bottlenecks should be considered if further investigation of the issues suggests that it would be useful.

6.1.2 Policy Dialogue on Regulatory Issues

Lack of public sector attention to contraception over the past twenty years has led to a flurry of activity to "fiscalize" activities in the sector now that the public sector is getting involved. Because of this neglect and of the attendant ambiguity in civil and medical codes regarding family planning, Brazil has not benefited from the many years of experience in other countries of addressing legal and regulatory issues in this sector in other settings. Examples of potential regulatory barriers include requirements for the testing of imported contraceptives and for the

registration and licensing of methods, as well as tariffs, state taxes, and hidden protectionism. Recent experience with the tie-up of large stocks of imported condoms owing to delays caused by testing procedures is a case in point. Norms for service delivery and public/private partnerships are also areas where dialogue could be fruitful. The proposed family planning legislation as well as current norms being promulgated by the PAISM unit in the Ministry of Health need to be studied closely for the effect they may have on effective collaboration between the private sector groups that USAID has been supporting and public-sector activities to which they could make important contributions toward sustainability and improved quality.

6.1.3 Linking Family Planning with Other Reproductive Health Issues

As noted in the introduction, USAID is supporting activities that address problems of HIV/AIDS and at-risk youth in Brazil that are expected to extend beyond the end of the population phase-out strategy. Both of these initiatives have elements that access reproductive health issues: for example, avoidance of high-risk sexual behaviors, avoidance of pregnancy in adolescence, prevention of the transmission of STDs and HIV from promiscuous husbands to their wives and yet-to-be-born children.

At the operational level, many of the public- and private-sector agencies implementing these projects are involved in other reproductive health activities, as is the case with family planning groups who are involved in HIV/AIDS prevention and work with adolescents. In many of the municipalities where AIDSCAP is operating, the decision was made not to separate HIV/AIDS work from other reproductive health activities.

Several of those interviewed commented that despite the close operational-level connection between the various elements of the reproductive health "package" being funded by USAID, the World Bank, and other doors, there is only limited coordination of these functional areas at the level of the project management in the Ministry of Health or in and among donor agencies. The reorientation of USAID's mandate in the Population, Health, and Nutrition field toward a more integrated approach offers an opportunity to put this new vision into practice in Brazil in a way that could contribute to the quality and sustainability of family planning as well as other elements of reproductive health over the coming decade.

7 CONCLUSIONS AND RECOMMENDATIONS

7.1 Conclusions on the Continued Validity of the Phase-out Strategy

USAID's Brazil phase-out strategy was designed at a time when important changes in the policy and program environment were occurring. A broader, client-centered approach to family planning as part of a package of reproductive health services had been called for in the Brazilian maternal and child health program (PAISM) in the mid-1980s, was recognized as a right of all Brazilian people in the Constitution of 1988, and was beginning to be implemented in some states under the newly decentralized health system by the early 1990s. Public sector involvement was also changing as a result of broader health reform and renewed interest in implementing PAISM, and this in turn has affected public/private partnerships.

When the strategy was developed, Brazil was already well along in its demographic transition, though with significant interregional differences in demographic and other social indicators. Many problems left over from years of public neglect of population remained, including the narrow range of choices of family planning methods and other quality issues, along with a concern about the sustainability of investments USAID had made in the sector over a 20-year period.

Further changes have occurred since the strategy was agreed upon, as noted in Chapter 2. None of the changes challenges the basic validity of the strategy, which in fact anticipated many of them, including Brazil's strong endorsement of the new vision of population articulated at the International Conference on Population and Development and in the mandate for USAID's Center for Population, Health, and Nutrition.

USAID's decision to focus its population assistance during the Brazil phase-out on a few issues (sustainability, quality of services, public/private roles), a few activities to address those issues (training, IEC, commodities, investments in for-profit activities, and research/evaluation), and in two states (Ceará's and Bahia) of Brazil's poorer Northeastern region was a sound one. The basic underpinnings of the strategy thus remain valid.

At the same time, some rethinking of the strategy is called for in reference to the time frame of phase-out activities, priorities among the different elements of the strategy, and opportunities to take advantage of changes in the policy and program environment. Macroeconomic constraints have and are likely to continue to limit the capacity of states to allocate adequate financial support to public-sector reproductive health services. The private for-profit sector continues to play a major role in health service delivery, including family planning. However, the goal of leveraging support of private commercial activities to stimulate a broader method mix and cross-subsidize services for low-income groups has proved elusive. Some re-thinking of this aspect of the strategy is needed.

7.2 Conclusions on Progress during the Phase-out Period

7.2.1 Improvements to Date and Emerging Needs in Program Functional Areas

Training. USAID has provided substantial support to training over the years and those investments have paid off in terms of a cadre of family planning/reproductive health professionals who are playing a leadership role in Brazil today. Much of this training has been in-service training. Of the five functional areas targeted for support in the current strategy, training has made the greatest accomplishments and is nearest institutionalization. By 1997, in both target states RH service delivery guidelines will be in place, sufficient RH training centers for training of physician and nurse providers will have been established, and sufficient trainers of physician and nurse providers will have been trained. In Bahia, specifically, training capacity will be nearly in place to meet not only general RH training needs but also those of adolescents. Key activities that merit immediate attention are curricula design and TOT for the training of auxiliary nurses and CHWs and preservice training for physicians and nurses. Beyond 1997, continued technical assistance for institutionalization of preservice training and training of providers with new responsibilities under new guidelines (e.g. training of nurses in IUD insertion) will require on-going support.

Management. Management has been one of the least emphasized of the five functional areas during the current assistance period. By 1997 most of the progress in the management area is expected to center around implementation of operational plans and improvements in MIS and evaluation and logistics systems, with greater progress in Bahia than in Ceará. These systems will be operational but not fully institutionalized by 1997, and will require continued assistance to be sustainable by 2000. Management TA and training need to be emphasized immediately to assure that support systems are in place after the phase-out period.

IEC. Progress in IEC has been slow during the phase-out period. Activities have been narrowly focused, primarily on IPC/C. Production of new materials has been slow in initiating, and stocks of materials produced before the phase-out are low. By 1997, IPC/C is expected to be incorporated into all RH training for physician and nurses, limited client IEC materials will have been produced and selected IEC materials for providers should be available. However, broader and more concerted IEC efforts are needed.

Commodities and logistics. Among the important changes that have occurred since the phase-out was designed are increasing demand for contraceptives, growing public sector involvement in the purchasing and distributing of contraceptives, and new private-sector initiatives in contraceptives procurement which appear to be sustainable. As the flow of USAID-funded commodities declines, reliance on alternative systems will increase. These channels have potential but need careful nurturing now and beyond 1997. Public-sector capacity is still weak, especially on the logistics side and in terms of the consistent financing needed to keep the system going.

Private-sector involvement. The progress here is mixed. The private-sector procurement organization (CEPEÓ) which has been set up to provide methods to groups formerly served by CPAIMC and Pathfinder, is expanding its markets, and is clearly on the road to sustainability. Results for the other private-sector activity, the effort to incorporate family planning in services provision by a major national health care organization (UNIMED), are poor. After a bad experience in Sergipe, the investment in Maceio may yield a financial return; however, the

objective of expanding family planning, especially for lower income clients in UNIMED facilities, has not been met, and there is little evidence that it ever will be under the current arrangement. USAID should address when and how to recover the funds invested and apply them to activities that contribute more directly to its strategic objectives. Given the short time period before phase-out and the time required to implement new initiatives, new activities should not be undertaken in this sector.

Research and evaluation. The 1991 DHS and 1993/94 situation analyses provide good baseline data for the phase-out. Additional research, completed or underway, will provide complementary information for evaluation. Beyond this, the flow of evaluation information is quite limited, especially that needed to plan for and measure progress in specific functional areas, such as IEC and training. Plans need to be made for additional DHS-type surveys (hopefully at the national level) and situation analyses in 1996/97 and beyond; for more systematic generation of program monitoring and evaluation information at the state and municipal level; and to establish a system for gathering the information needed for USAID program indicators on a regular basis.

7.2.2 Improvements in Quality of Care

Method diversification. There is some indication of greater availability of a wider range of contraceptive methods in program areas. At the same time, new survey findings show a much more substantial jump in surgical sterilizations (at the expense of pills) in Ceará from 1990 to 1994, although the most recent measurement was only one year into the current assistance period. From the limited information available on method mix, there has been very little improvement in diversifying method use, though a regional/national survey is needed to confirm this. To date, considerable emphasis has been placed on expanding IUD use and less on other low-prevalence methods.

Improved method use and wider availability of RH information. DHS and situational analyses are the main sources of data on method use and availability of RH information. Since second rounds of both surveys are to be conducted later in the assistance period, no data are yet available to document improvement in this area.

Other quality considerations. Baseline situational analysis data (available only for Ceará) suggest important differences in quality indicators between the metropolitan area of the state capital and other municipalities. Thus, while general improvement is needed at the state level, efforts at improving quality should focus particularly on municipalities outside of the metropolitan areas. In addition, special efforts are needed to disseminate information on QOC and to train and inform providers about quality issues.

7.2.3 Institutional Sustainability

BEMFAM. BEMFAM's current sustainability plans do not show that the institution would be any more sustainable once USAID funding and commodities are terminated in 1997 than it would be if that support were to terminate immediately. The projected 52 percent cost recovery by 1997 is questionable because:

- The cost of donated commodities has not been imputed into the sustainability equation.
- BEMFAM is relying on generating considerable revenue from contraceptive sales, yet the institution lacks experience in the commercial sector.
- National-level protectionist policies are expected to impair short-term entry into the condom market.
- The states, in the medium term, are likely to develop their own purchasing arrangements for commodities, thereby eliminating the revenue generation niche that BEMFAM has historically relied upon.

Aggravating the situation are mixed messages from different donors regarding the urgency of taking concrete steps to insure sustainability.

Pathfinder-supported activities. The most significant activities that Pathfinder support are well along the continuum toward sustainability. The SESAB MIS and contraceptives logistics systems designed and managed by Pathfinder are in the process of being decentralized, although they are not expected to be entirely institutionalized by 1997, and will require some outside assistance. PP/PA family planning services are well on their way to becoming institutionalized in Bahia and will probably not require outside support after 1997. Institutionalization of these services has been less successful in other northeastern states, including Ceará. Pathfinder's function as a distributor of commodities is in the process of being transferred to CEPEÓ. Maintaining low prices will be key to assuring a sustainable supply of contraceptives to NGOs that currently rely on Pathfinder for commodities. A new sustainable information dissemination vehicle, as an alternative to *Planejamento Agora* needs to be identified.

Government programs. State-level programs in Ceará and Bahia have made substantial progress over the last three years, mainly in setting up institutional mechanisms at the state level and mobilizing high-level political support for family planning/reproductive health. At the same time, the political and financial bases for these activities are still fragile, particularly in municipalities, which will have increasing responsibility for service delivery. UNFPA is assisting Ceará and intends to add one other state. Some funding is available through the World Bank's NE Basic Health project. The chances that these programs will be financially sustained after 1997 without outside support, however, are slim. The public sector will not be technically sustainable by 1997, although some functional areas (such as training) will be more institutionalized than others. Technical assistance will need to continue through 1999.

Private sector. Private-sector initiatives (CEPEÓ and UNIMED) appear strong on financial sustainability. CEPEÓ is already purchasing IUDs with its own capital. While it continues to underwrite key salaries with USAID funding, by the end of 1997 it is expected to be fully

sustainable with no USAID funding. UNIMED's medical facility is expected to break even by late 1995 and the MCH clinic in 1996.

The main issue with UNIMED is that it is not contributing to USAID's overall objective of using a private sector network to improve access to or expand family planning services. At the beginning of the venture, the CPR for UNIMED beneficiaries was much higher (75 percent) than the general population (54 percent); the family planning service delivery mechanism under implementation to reach needier populations has not created a replicable model for integration of family planning services into the private sector, and; UNIMED management and physicians are not particularly interested in family planning and not willing to serve low-income women. In addition to UNIMED, PROFIT is looking into other private sector ventures in Bahia.

7.3 Recommendations on Functional Areas to be Strengthened and/or Specific Activities to be Undertaken to Assure Effective Phase-out

7.3.1 Training

1. To meet the training needs that have been identified above, it would be useful to have someone step back and conduct an informal inventory of training investments up to now (who was trained, in what, and where they are now) and to identify specific gaps that need to be addressed. During the remainder of the phase-out period, USAID should recognize the critical role of preservice training and seek opportunities to address preservice training and in-service TOT. TOT courses for trainers of auxiliary nurses and CHWs should be implemented. The current effort to design and disseminate state-level guidelines needs to take account of federal regulatory mandates in this realm.

7.3.2 Management

2. Attention should be given to improving financial management and administration capabilities of state and municipal-level health council staff who are now responsible for planning, budgeting, and monitoring their own health system. Management training is needed in logistics management, financial planning, human resources development, and in design and use of information systems. Municipal officials also need assistance in dealing with changes arising from the health care reform process.

7.3.3 IEC

3. IEC material production should be accelerated to replace stock that are rapidly becoming depleted. Attention should be given to materials that provide information to users (actual and potential) and providers about alternative methods to the pill and sterilization, and about correct use of the pill. IPC/C TOT should be expanded to include auxiliary nurses and CHWs. Policy communications efforts are also needed to inform municipal officials of the importance of family planning and reproductive health services to their communities. Demand-generating activities should also be implemented as appropriate. Given the limitations on USAID funding, coordination with

other donors (UNFPA and the World Bank) and the PAISM unit in MOH is needed to achieve these IEC objectives. IEC for users and providers of new methods will not be effective unless those methods are available, so that financing, management, and logistics issues need to be addressed in tandem with IEC efforts.

7.3.4 Commodities/Logistics

4. Emerging public-sector involvement in the forecasting, procurement, tracking and distribution of contraceptive methods urgently needs to be strengthened. Brazil's essential medicines program is functioning but weak; still, it has successfully distributed vaccines nationally even under very difficult circumstances. Adequate financing is required (IEC, policy dialogue could help) as well as training in logistics and procurement procedures. This functional area should receive high priority attention.

7.3.5 Evaluation/Research

5. Evaluation and research should also be strengthened. A full monitoring and evaluation plan for the program should be completed, and procedures for regular reporting established. Baseline and target levels need to be established for all indicators in the evaluation framework. CAs' activities need to be integrated more fully into the monitoring and evaluation plan. Roles and responsibilities for managing the program's information system should be clearly established. Plans need to be made for the next DHS survey, so that another round of population-based data will be available for 1996-97. Broader institutional participation in the next DHS round should to be explored. The situation analysis research program should be continued.

7.3.6 Private Sector

6. CEPEÓ has strong potential to contribute to sustainability and quality goals in other functional areas and institutions. This potential should be encouraged by investment of additional resources during the phase-out period, if necessary. On the other hand, the strategy for increasing access to and expanding family planning services among underserved groups via the HMO sector (UNIMED) has not been successful. Consideration should be given to how resources invested in UNIMED can be freed and applied to activities that are more likely to contribute to USAID's strategic objective. Based on other priority needs, the time required to undertake new initiatives, the short phase-out timeline and limited resources available, other private sector ventures should not be pursued during the phase-out period.

7. As money tied up in the UNIMED investment in Alagoas is recovered, it might be used to establish a trust fund to support reproductive health activities as USAID assistance is phased out. Delineation of the range of activities covered by such a fund is beyond the scope of this report; however it is the view of the team that this use of the remaining funds would contribute more to USAID's phase-out objectives than continuing with the relationship with UNIMED or trying at this late stage to find some alternative for-profit health service investment opportunity.

7.3.7 NGO Sector

8. Major changes in the management and organizational approach of BEMFAM are needed to put the institution on a path toward sustainability: restructuring and decentralization of management, down-sizing of the Rio office, closing of clinics that do not break even, aggressive marketing of laboratory services in states where they are profitable, and development of a financial plan for phasing out USAID commodities. Without such changes, further funding will only prolong an inevitable funding crisis in 1997. If BEMFAM will commit itself to these changes, USAID should continue funding BEMFAM; if not, USAID should withdraw funding and apply the resources to other needed investments. USAID should be prepared to support BEMFAM in this final effort to become sustainable through training of managers in such areas as marketing, pricing and cost containment.

7.4 Recommendations for Changes in the Current Phase-out Plan and Priorities in Case of Accelerated Phase-Out

7.4.1 Overall Objectives

9. The two central objectives of the phase-out strategy, sustainability and quality care, should be maintained, as well as the regional focus on the Northeast in the two states of Bahia and Ceará. Selected national-level activities should also continue, though with greater emphasis on actions to improve public-sector capacity in key areas (management, commodities, training, IEC) that relate to the sustainability and quality of services to groups who rely on the public sector for services.

7.4.2 Priorities

10. Public sector assistance should continue, though with greater emphasis on actions to improve capacity and institutionalize activities in key functional areas (management, commodities, training and IEC). Efforts to enhance private sector involvement in family planning should continue, although with less priority, and not through investments in HMOS. Public-private partnerships should be promoted.

7.4.3 Specific Recommendations

11. Give top priority to improving public sector financial and managerial capacity to supply contraceptives and other reproductive health pharmaceuticals and implement decentralized service delivery systems.

12. Continue to build public sector in-service TOT capacity for physician and nurse training, while increasing emphasis on TOT capacity for auxiliary nurses and CHWs.

13. Explore preservice training opportunities in schools of medicine and nursing in the target states, building on previous USAID investments in this area.

14. Broaden IEC efforts: accelerate production of IEC materials; implement demand-generating activities (i.e. mass media campaigns); focus on all target audiences (current users, potential users, providers and municipal officials); continue with TOT in IPC/C and building of IEC staff communication skills.

15. Complete the evaluation framework immediately, as well as the monitoring and evaluation plan, and implement monitoring systems.

16. Support a DHS in 1996, leveraging resources from other donors, and situation analyses in 1996/97.

17. Assure that all activities, particularly those involving training, IEC and commodities, are clearly designed and carried out to become institutionalized within the organizational structure of the public sector.

18. Disseminate information about QOC and assure that activities to improve QOC focus as a whole on all contraceptive methods.

19. Withdraw funding from BEMFAM unless profound managerial and organizational changes designed to increase its chances of being sustainable by 1997 are implemented within six months.

20. Negotiate withdrawal from the UNIMED venture, striving for recovery of the original investment adjusted for inflation and opportunity cost.

21. Continue support for the CEPEÓ, increasing support if necessary to assure a sustainable source of reasonably priced contraceptives upon USAID phase-out.

22. Make no further investments in the private sector unless they contribute to USAID's strategic objective.

23. Establish a trust fund, with funds divested from the UNIMED venture, to be used to support public-private partnerships as USAID funding is withdrawn and beyond.

24. Plan for continued support to the public sector after 1997 for specific activities in a limited number of functional areas, particularly contraceptive logistics, management and preservice training for medical and nursing students. Technical assistance with TOT training for specific provider groups (such as nurses) and for selected IEC activities will also probably be necessary.

7.5 Recommendation in the Event that Bilateral Assistance Becomes Possible

25. Because such a change would come relatively late in the phase-out process when resources have already been scaled down, direct involvement with the public sector

would have to be very selective. It should focus on key needs such as commodity procurement and logistics. Policy dialogue could focus on such issues as service delivery guidelines, public/private partnerships, and trade and regulatory obstacles to imports of commodities or inputs for local manufacturing.

7.6 USAID-Supported Activities that Should Continue After 1997

26. The public sector will require continued technical assistance beyond 1997, particularly in the areas of management (including information systems) and contraceptive logistics. Technical assistance with preservice training, TOT training for specific provider groups and for selected IEC activities will also likely be necessary.

7.7 Recommendations for the Post-USAID Population Assistance Period

27. Efforts to strengthen reproductive health dimensions of HIV/AIDS prevention and youth projects during the remainder of the phase-out would help to continue focus on reproductive health after 1997. Policy dialogue on key issues such as public/private partnerships could also continue. Depending on the capacity of the USAID mission or of a CA such as Pathfinder that might continue to work in Brazil after 1997, it might be possible to promote involvement of U.S. private organizations in the post phase-out period.

28. The strategy calls for research and evaluation activities on overall program impact to be completed during the period 1998-2000. A national-level survey is an essential requirement for an adequate assessment of overall program impact. Such a survey should address other reproductive health issues in addition to fertility and family planning. It would be useful to set aside funds for a post phase-out review of overall impact and of lessons learned during the more than 20 years of USAID population assistance in Brazil.

29. The creation of a trust fund should also be considered to continue private-sector assistance to the public sector during the post-assistance period.

7.8 What is USAID Leaving Behind after Phase-out?

USAID support has played an important and evolving role in the development of family planning in Brazil. During the 1970s and 1980s, USAID funding of non-governmental organizations helped to legitimize family planning in Brazil and establish mechanisms for service delivery through a variety of channels. Private providers have become increasingly important in the delivery of all health services in Brazil, and this is reflected in family planning and reproductive health. USAID supported non-governmental organizations such as BEMFAM, SAMEAC, and PROPATER have provided training and IEC support, set standards, played an advocacy role, and helped to channel subsidized contraceptives to groups who have been poorly served by the private system. USAID-supported activities have also been at the cutting edge of efforts such as the move to broaden the method mix and improve the quality of services.

The 1990s have brought a renewed focus on the role of the public sector in the provision of health services, including family planning. For a variety of reasons, public-sector support of family planning did not materialize during the 1970s and 1980s. At the same time Brazil's new constitution guaranteed universal access to health services (including family planning) to the population, and the health reform movement in Brazil has been devolving responsibility for heath care service provision from previously highly centralized service-delivery structures at the federal level to the states and municipalities. Part of the growth in private-sector provision has been the result of uncertainties about the public sector's capacity to deliver on its commitment in the face of continuing financial and organizational challenges. At the same time, the expansion of private services has benefited mostly the middle- and upper-income groups, and there is growing recognition in Brazil that the main role for the state is likely to be ensuring access to services for the low-income population, which is poorly served by both the public and private sectors.

The fact that this transition is occurring at the same time that USAID is phasing out population activities in Brazil poses some special challenges from the point of view of ensuring that USAID's earlier investments continue to have an impact after the phase-out is completed. From USAID's perspective, the most effective contribution to the successful outcome of this transition is likely to occur through public-private collaboration and utilization by the public sector of the trained professionals and technical capacity in private institutions that USAID has helped to develop over the past two decades. Effective public-private partnerships are essential to both objectives of the USAID phase-out strategy; that is, improved quality of services and sustainability (because improvement in the quality of publicly provided services is not likely to occur without the help of private-sector experience and expertise) and for the organizations which USAID has funded over the years to find alternative sources of funding through subcontracting for activities such as training and IEC, or through reimbursement schemes for provision of services in order to achieve sustainability.